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REAUTHORIZATION OF THE CHILD ABUSE PREVENTION AND TREATMENT ACT OF 1974

HEARING

BEFORE THE

SUBCOMMITTEE ON
CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

ON

EXAMINING PROPOSED LEGISLATION AUTHORIZING FUNDS FOR THE CHILD ABUSE PREVENTION AND TREATMENT ACT

APRIL 1, 1987

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REAUTHORIZATION OF THE CHILD ABUSE PREVENTION AND TREATMENT ACT OF 1974

WEDNESDAY, APRIL 1, 1987

U.S. SENATE,
SUBCOMMITTEE ON CHILDREN, FAMILY,
DRUGS AND ALCOHOLISM,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:05 p.m., in Room SD-562, Dirksen Senate Office Building, Senator Christopher J. Dodd (Chairman of the Subcommittee) presiding.

Present: Senators Dodd, Cochran, and Thurmond.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. The Subcommittee on Children, Family, Drugs and Alcoholism will come to order.

At the outset, let me first of all apologize to all of you for being slightly late, but we are in a somewhat confusing situation on the Floor of the Senate right now, with the veto override, or attempted veto override, on the Highway Bill. And before getting into the substance of my opening remarks and calling upon our first panel of witnesses, I would say for the record that we are going to do our very best to proceed here in a very orderly fashion and go through the testimony and the questions.

However, there is a slight possibility that we may get derailed here this afternoon because of other matters that come up on the Floor. You do not plan these things; they just happen to you. And so we are just hoping it does not happen to us. So any of you who have any special connections with the Leadership of the Senate, either Republican or Democratic, and would like to see us complete this hearing, I urge you to make whatever calls you think may be necessary.

Having said that, let me thank all of you for coming here this afternoon. We had a very good press conference this morning, this being the first day of April, as we kick off a month-long recognition of the efforts to prevent child abuse in this country. We had good participation by Congressman Major Owens of the House of Representatives, Senator Gore, and others. We talked about various things that can be done by the private sector, by the Congress, and others concerning child abuse.

At any rate, this afternoon we are going to look at one of the most serious problems facing children, families and the Nation—

namely, the crisis presented by the growing number of child and youth deaths.

By very conservative estimates, reports of child deaths from abuse or neglect jumped 29 percent nationwide between 1985 and 1986. The victims are more often than not our youngest citizens, with many failing to reach their first birthdays. Some die as a result of serious physical abuse. Others die from injuries sustained while home alone without any adult supervision. Yet others die because their families fail to secure timely and adequate medical care.

Whatever the cause, their untimely and preventable deaths are casting a growing and darkening shadow over our families, our communities and our country.

Perhaps even more tragically, these deaths do not stand alone. Infant deaths associated with poor maternal and child health care in parts of our cities are as high as those in some of the poorest developing nations, ranking us at the bottom of 20 industrialized nations with respect to infant mortality.

The teenage suicide rate, which peaked in 1977, has begun to climb again in alarming clusters. And avoidable injuries remain the single biggest killer of children after the first year of life. Young people between the ages of 15 and 24 years of age are four times more likely to die from car crashes, drownings, firearms and fires than from any other cause.

This country has already the dubious distinction of being the only industrialized nation in which children constitute the poorest age group in our society. We also have the highest teenage pregnancy and infant mortality rates in the Western industrialized world.

To add high rates of child and youth deaths across-the-board to this profile of American childhood would be untenable. And given that the numbers of child deaths in this country appear to be climbing, I am introducing today a bill to mandate an immediate Federal focus on this crisis. Under this legislation, a Presidential commission would report within one year on the causes and possible remedies for child deaths associated with abuse, neglect, poor health care, sudden infant death syndrome, accidental injuries and suicide.

Given that we lack uniform data on child and youth deaths both within and across States, the call for a Presidential commission comes, I believe, none too soon.

We know more about the number of stolen automobiles in this country than the number of children whose lives are snuffed out by fires while home alone. Yet without such vital information, we will continue to look at such deaths as isolated incidents, failing to prevent or combat them in any coordinated fashion.

What little we do know about child deaths should give us greater cause for alarm. We do know that in as many as 25 to 50 percent of all child abuse fatalities last year, the families involved were already known to local child protective service agencies and workers. In at least one State, every child death involved a child previously identified as having been abused or neglected. It therefore makes good sense to examine the rise in child deaths within the context of the reauthorization of the Child Abuse Prevention and Treatment Act.

Child abuse fatalities, however, should not stop us from examining some of the very real progress made as a result of this landmark, albeit relatively modest program. In many ways, over the past decade, this legislation has had great success in encouraging and assisting some 38 States to establish special procedures to prevent, identify and treat child abuse and neglect.

Perhaps the most eminent and successful peer group working with abusive parents from Connecticut to California, Parents Anonymous, was started with seed money from this Act. And the National Center on Child Abuse and Neglect was founded, to make the prevention and treatment of child maltreatment a foremost priority in this country.

Other real signs of progress are numerous. As I reviewed in two previous hearings of the Senate Children's Caucus, which I cochair, the surge in reports of child sexual abuse in recent years demonstrates greatly increased public awareness and concern. And overall prevention methods, augmented by children's trust funds in 38 States, have made real strides.

As the author of the Federal Challenge Grant Program for Children's Trust Funds, I intend to hold oversight hearings specifically on prevention sometime this fall. With respect to this hearing, however, the crisis presented by child deaths sends us a clear signal that under-funded and over-burdened local and State child abuse agencies need immediate assistance.

To the detriment of children and families, the Prevention and Treatment Act has never been well-funded. In 1981, the authorization levels were cut in half, and any separate funding for sexual abuse projects was eliminated.

Although an amendment I offered three years ago to restore such funding was eventually enacted, we are only now starting to catch up to where we were six years ago with respect to Federal leadership in the area of child abuse.

In the meantime, reports of abuse and neglect have skyrocketed within the past decade. In South Carolina, the caseload jumped from 1,900 reports in 1978 to 17,544 reports in 1986. In Connecticut in 1978, we had 9,140 cases; in 1986, 11,182 cases. So this increase in reported cases of physical and sexual abuse has been no less dramatic in most other States across the country. Such staggering increases have only exacerbated absenteeism, burnout and turnover among child protective service workers.

In one New York City agency last year, 86 percent of the staff either transferred or quit. Another agency in Florida reported workers struggling with 100 cases or more as a result of staff turnover.

At the same time, cutbacks in Federal funding has forced many States to make hard choices indeed. As the Child Welfare League of America revealed last year in a study of child abuse, workers and agencies all too often must make investigating reports of the neglect and abuse of older children a lower priority, based on the theory that older children can at least run away from home.

As a member of the Budget Committee, I will be pressing for increased funding for the legislation we are hopefully authorizing today. I will also be working to restore funding for the Title XX Social Services Block Grant, which provides some funds to train, hire, and retain child protective service workers. Title XX funding was cut by 21 percent in 1981.

In addition to restoring resources for local and State agencies, the Federal Government has, I believe, a very strong leadership role to play in combating child abuse. As our witnesses this afternoon will tell us, basic research funded by the National Center on Child Abuse and Neglect can help identify why some children who are the victims of abuse or neglect experience early school failure or become depressed, socially withdrawn and aggressive while others do not. The National Center can be alerting States to new and innovative prevention, identification and treatment approaches developed by their neighbors.

As other witnesses this afternoon will explain, the special risks of abuse faced by children with disabilities as well as the risk of permanent disabilities stemming from abuse ought to be examined in a comprehensive manner by the National Center.

And last but not least, by working in conjunction with other Federal departments, the National Center on Child Abuse and Neglect can assist States to set up uniform reporting systems. In that way, we will have a total picture of all the risks of abuse and neglect young Americans face, including the tragic risk of death.

Three years ago, I was pleased to join with my colleagues across the aisle to address the very real problems symbolized by the medical neglect of so-called Baby Doe infants. We worked very hard to craft compromise language encouraging States to develop special procedures to prevent such tragedies. This year, I hope we will pay the same painstaking attention to the very real crisis presented by child abuse deaths. To do any less short-changes the future of our families, our communities, and our Nation.

I thank you for listening patiently to that opening statement.

We are going to do something different with the hearing here this morning, and I will explain why. Normally, I would ask the Administration witness to appear first, and then we would have the other witnesses come afterward. But the Administration, to its credit in this particular case, has requested that we put on the other witnesses first so that they might hear the testimony and develop some ideas. Too often what happens, of course, is the Administration will testify and then disappear from the room and not hear the testimony of others. So today they are going to do it a bit differently, and Dr. Jean Elder will be our third witness, and I appreciate her willingness to do that.

Our first panel this afternoon will include Linda Hull. She is part of an organization called Formerly Abused Children Emerging in Society, or FACES. She is from Wethersfield, CT. I would ask Ms. Hull to approach the witness table.

And Cloe Madanes, Co-Director of the Family Therapy Institute of Washington, D.C.

We will ask you both to come to the microphones, and we will accept any prepared statements you have. I would urge you to paraphrase them if you would like, but we will include your prepared remarks in the record. So however you wish, feel free in proceeding.

We will begin with you, Ms. Hull.

STATEMENTS OF LINDA HULL, FORMERLY ABUSED CHILDREN EMERGING IN SOCIETY, (FACES), WETHERSFIELD, CT; AND DR. CLOE MADANES, CODIRECTOR, THE FAMILY THERAPY INSTITUTE OF WASHINGTON, DC, ROCKVILLE, MD

Ms. HULL. Okay. I do not have any prepared statement, but I will read from my notes a little bit.

Senator DODD. Fine.

Ms. HULL. I have a list here of characteristics of adults who were abused as children. And what I am going to do is pick out the ones that are most important to me, and tell you what it feels like to have been abused so that I have these characteristics. Okay.

The most important one for me was the feeling of isolation. This feeling of isolation was caused by many different things that were done to me.

My mother died when I was a small child, and my father remarried, and the person doing the abuse mainly was my stepmother where my father, who was the "good guy" kind of stood back and let her do it.

How she would isolate me is she did not like people to compliment me or show affection for me or interest in me. Like if they went out for the evening, and the babysitter said what a nice little kid I was, she made sure that I was punished by going to bed after supper the next time the babysitter came.

My aunt will corroborate this, but she said she came to visit—I guess it was more than once—and she was not allowed to see me. I had been sent to bed for something. And one time, she just went in anyway and came in and talked with me. And I can remember feeling very excited that my aunt was coming, and hoping like anything that she would come in the room and see me, and just being elated when she just came in to talk to me.

It took an act of Congress for me to get out of the house and see people, so that it almost was not worth it. My stepmother had to control every bit of food that I ate, to the point where I was hungry all the time; I was quite thin and did not have a lot of energy.

To give you an example of the control over food, it was like this. We had a piano in the house, and I took piano lessons. We used to have recitals at the piano teacher's house. We would get all dressed up in little dresses or suits, and we would work very hard on our pieces. We would go to the piano teacher's house, and we would play our parts, and I would get very nervous about it, you know, like anybody would who is going to perform in front of a group. And then we would have sundaes afterward, and we would have cookies with the sundaes. Well, I knew I was only supposed to have two cookies, and I would be fighting with myself—do I take another one?

And then, as soon as I got home, instead of saying, "Did you have a nice time? Did you play well? What were the other children like?" or anything like that, she would say, "How many cookies did you eat?"

She had no concern whatever as far as my development as a child. It was just this control issue.

I spent years sitting out in the back yard, winter and summer, not allowed to leave; like I said, I had to ask to cross the street until I was 18. And sometimes, kids in the neighborhood that liked me would come and sit with me for a while. But if they could not do anything or go anywhere, why were they going to stay with me? So after a while, they would leave.

Okay. The feeling of isolation was also exacerbated in that she also controlled how much I washed. And when you feel unclean anyway, that just gives you another reason to stay away from people; you are not clean.

So I was isolated from the time I was about five—it began slowly, and then escalated—until I was eighteen, when I left home. So that by the time I left home, I did not have the social skills necessary to make new friends, and I got into other abusive relationships, which I subsequently did get out of.

But I am 37 now, and it has taken me many, many years to—I do not know—make up for the damage that was done—of very slow, patient work on my part. I do not feel isolated anymore.

I also was isolated because when I left home at 18, (and I swore to myself I would never sleep under their roof again, and I would never allow any children that I ever had to sleep under their roof—that has come to pass; I have never done that—) I kind of broke the ties with my family. I call my father maybe two or three times a year. Otherwise, I do not see them. I have a relationship with my sister and my aunt and a couple of others, but that is it. It is not a high-level involvement. There have been times when I had no place to go on holidays and things.

So I also have been isolated because of a lack of extended family, and I have had to—which is no problem to me—make friends to make up for that. So now, I have a lot of friends and lot of places to go and things to do. But it has taken me many, many years.

So that is the isolation that child abuse causes. That is what it means to me.

An overdeveloped sense of responsibility. I felt that I was used as someone to work in the house. I had a lot of responsibility as a child and a teenager in taking care of the house, like ironing all the clothes when I was 14, constantly raking the yard, doing the dishes. The first thing I got up in the morning, it was work, and then eat breakfast after that, and then go to school. It was not, "Hurry up, get ready for school, get your books together, get your clothes on." None of that. It was get up and work and then go to school. It was just housework, ordinarily. This was a suburban home. And then as soon as I got home from school, more work.

And I always had the feeling that with my youngest sister—I took care of her a lot until she was about three years old. I loved my sister very much. I am seven years older than she, by the way. Whenever she came out to play, I had to drop everything I was doing and take care of her, which did not bother me. This went on for a couple of years, and then as soon as she was three years old, my stepmother did not want me to have contact with her anymore, and kind of broke it off so that there was not much of a relationship after that, which I do not think is fair.

So I do have the overdeveloped feeling of responsibility, and in the past, this meant that I always felt responsible for everything that happened to everyone around me, which is not true; I know that now.

The inability to trust. If people have been a cause of negative inputs into you, it makes you afraid to be with people or to get close to them, because you think that these new people are going to do what others have done. So for years, this problem bothered me a lot. I could not get close to people. I was not able to become close to people until I started college in 1977 and I had one relationship with a male person—it was a friendship—where I realized that he was not hurting me, that the painful feelings I was experiencing were not coming from other people all the time, but they were coming from me and my fears. And I made the decision that I wanted to learn how to be close to other people. My life changed since that point, just from that one relationship, and very, very slowly my relationships became better and better.

But I spent many, many long years in bitter loneliness.

Do you want me to go on? I have more on this list.

Senator DODD. Well, why don't you just take a couple more minutes and go down through some of those. They are very important.

Ms. HULL. Okay. Low self-esteem, the feeling of being unlovable. I felt that I was to be used for someone else's needs, taking care of my stepmother; being quiet when she was taking a nap, to the point where it was almost impossible to open a door because she would get angry with me. I was afraid to go home every day of my life.

The feeling that I had nothing to offer to anybody. Why would someone that I liked want to be my friend? I had nothing in common with these other people, and I had nothing to offer. But that is not true. I had to learn that that was not true.

Fear of conflict, authority, people who are merely asserting themselves, and fear of anger from other people and from myself. Terrible fear of expressing any angry feelings that I have to the point that for years I bottled it up and poisoned my relationships.

Someone saying the mildest, meekest little thing to correct anything I did or said would cause me to be extremely defensive. I was very, very defensive in the past.

Fear of conflict and arguing and fights and things.

Harsh self-criticism. I experienced that on my job. If I did something good at work and people say, "Oh, you did a good job today," I would feel like I had done the best thing in the world. Whereas if I even had a good day, and I thought I could have done one thing better, I would just criticize myself, just go over and over the situation to see what I had done wrong and what I could do better. It was debilitating. But I have been practicing as a nurse now for a few years, and gradually, those problems have kind of receded.

Compulsion to be perfect. I tried hard to please my stepmother. Nothing I ever did was right. I could do one thing one day and get punished for it, and the next day get punished for doing the opposite thing.

Another thing that helped me was going to college. I went to college, and I had a chance to meet a lot of new people. And I remember in specific three people I was friends with in the year 1978, and my whole life was changed. The best way I can say it is I was not able to appreciate the fact that other people are the most important things and the most beautiful things in life; it is not what you do, it is other people. And like I said, that one relationship helped me make the decision to change myself, but I think even the person I had this relationship with did not make the same decision I did. He had been a battered child, and he had scars on his body that I counted, 13. He did not make the same decision I did, so we have not travelled the same path since that time.

Senator **Dodd**. That is very helpful.

Ms. **Hull**. I hope so.

Senator **Dodd**. I will have some questions for you in a few minutes, and maybe you will have a chance to respond to some other things.

Dr. Madanes, did I pronounce your name correctly?

Dr. **Madanes**. Madanes.

Senator **Dodd**. Dr. Madanes, we are delighted to receive your testimony this morning as well.

Dr. **Madanes**. Thank you.

I am going to talk first about what we know, and then I would like to talk about what I think we must do. So I will start with what we know.

We can predict who has a higher chance to be abuse or to be an abuser. Victims at special risk are disabled children, runaways, and children of those at high risk to be abusers.

At highest risk to abuse are: former prison inmates, parents who are mentally retarded, those who have been diagnosed or hospitalized for mental illness, alcoholism or substance abuse, or charged with drunken driving, parents who are isolated or homeless, teenage parents, those who have a previous history of assault or suicidal behavior, the unemployed, those who own weapons or have been previously arrested for a crime. These people frequently show up in emergency rooms, and they are a red flag for early intervention.

Senator **Dodd**. Excuse me one second. When you are talking about at highest risk to abuse—that is those who are likely to be the abusers, of course?

Dr. **Madanes**. Yes.

Senator **Dodd**. All right. I was a little unclear.

Dr. **Madanes**. There is no mystery. We can predict. Most abusers have been in prison or in mental hospitals before. There are even studies on predicting abuse in the delivery room. Mothers in the delivery room who do not go through the usual inspection sequence of their babies, who do not count the baby's toes and make sure the baby is complete, have a higher chance of becoming abusive or neglectful.

We know that services must be provided for those whom research has shown to be at highest risk to abuse or to be abused.

We also know how many children are abused. A recent national survey projected that nearly 1.5 million children and adolescents are abused each year. More than 25 percent of all women are sexually abused before age 16.

We know that the victims of physical and sexual abuse have a high chance of becoming offenders later on in life. To prevent child abuse is to prevent crime, because the victims of today are the criminals of tomorrow.

We know that child abuse reflects the violence at all levels of society and is encouraged by the portrayal of violence in the media.

We also know that abuse is at the base of severe mental illness and of physical illness later in life. To prevent child abuse is to prevent severe mental and physical illness in adults.

We know that protective services and the court system often add insult to injury. Poorly trained, poorly paid, overworked service providers place or misplace children in inhumane ways with inappropriate, unqualified foster or adoptive parents.

We know that often abuse is committed by people who work with children, such as teachers, priests and daycare workers. We know that they should be carefully screened.

We know that in order to thrive, children need one strong, nurturing, loving bond with a stable adult. Once a child has been abused and damaged, we know that the first priority is to protect this bond or to create one if it does not exist. We know that this bond can best be found in the extended family network of the child, rather than in foster homes or in institutions.

What I think we must do:

We must protect the Nation's children. This is a human rights priority. We must do this without any cost-effectiveness consideration. It is immoral to talk about cost-effectiveness when we talk about children's lives. The protection of our children will not come cheap, and we cannot be cheap in planning for it.

Child abuse services must be totally reorganized. A Federally-centralized effort is necessary to overhaul and infuse effectiveness and quality into an underfunded, undertrained and unprofessional bureaucracy.

Too many cities now have incompetent services, insufficient staff and unaccountable programs. The States, through block grants, now distribute moneys while neglecting to set up high standards of professional care.

Protective services must become very professional. The best, high-quality, family therapists should be involved in training the professionals who will work to protect the Nation's children.

Abusers can be detected, abuse can be prevented and stopped. Children can be helped to overcome the trauma of abuse when qualified professionals are employed.

At our Family Therapy Institute for the 11 years that we have been in existence, working with 300 to 500 families each year, there has not been one case where a child was abused while the family was in treatment. Family therapists can teach and supervise other professionals to accomplish the same results. Abusers are like the chronically ill; they need continuous vigilance by qualified professionals for a long time.

Child abuse services should be reorganized under tight control of a pediatric, judicial and family therapy board responsive to Congress.

Perhaps the Children's Defense Fund should be strengthened and given a service arm and an overseeing executive function. perhaps a Department for the Protection of Children, similar to the Department of Health and Human Services, should be created.

Family evaluation and treatment clinics should be organized. They should consist of teams of family therapists, pediatricians and legal professionals working in collaboration. The current arrangement of child advocates and parent advocates in adversarial positions is not in the best interest of the child. Family therapists are a must. Family-oriented training for pediatricians, for social services, and for the judiciary must be funded.

The training of family therapists themselves must be encouraged and funded. Today the evaluation of families is not based on family theory. Each family member is seen as a separate individual. A problem-solving-based evaluation must have family therapy theory behind it, and must include grandparents and the extended family network, without assuming that the nuclear family can be kept together.

Foster care and adoption services as well as services for runaways must be linked to the family evaluation and treatment clinics.

Lawyers and judges must be educated and supervised. Judges today dismember families without engaging appropriate supportive, therapeutic or penal services. They mandate treatments that do not exist. Foster care and adoptive services are scandalously neglected and inadequate. Children are being robbed of their rights as citizens of this country.

We must encourage the participation of pediatricians in the detection and prevention of abuse. We must develop attractive grants and fellowships for pediatricians to choose this area of expertise, particularly for those interested in outreach. Delayed services are fatal.

We should develop a "Child Watch Year" as a national campaign to create an atmosphere of heightened awareness and concern. We need to make the protection of children every citizen's obligation. We must all share responsibility, improving vigilance and supervision, and fostering an atmosphere of tolerance and nonviolence.

We must deter the depiction of violence and exploitation in the media. We must allocate funds for creating materials for television that promote self-restraint, respect and nonviolence. We need to set up a committee for monitoring violence in the mass media.

We need to develop a nationwide system of high-quality daycare so there will be less overstressed, undersupported, neglectful parents. We must break the isolation of families that is so often associated with abuse.

We need to support and finance natural groups such as Networks of Concerned Parents, with a self-help emphasis. Churches, schools and all kinds of social organizations must be encouraged to become involved in the lives of children and in the empowering of positive parenting.

Child abuse is related to unemployment. We must not forget that jobs and equal opportunity for an education prevent despair and violence.

With 50 percent of children living in divorced families, the family is not what it used to be. The community needs to become more involved in the protection of children as the structure of the family changes. Cost should not be a consideration, but the prevention of abuse will save the cost of criminal behavior, violence, and mental illness in the future.

I have proposed an expanding program for child abuse, beginning with skillful treatment for each child and family, proposing changes in the judiciary, medical and social service areas, giving national priority to a campaign for child protection, and controlling the influence of the media, as well as emphasizing the importance of improving the economic situation of families as it relates to the welfare of children.

Thank you.

Senator Dodd. Thank you very, very much for your testimony. Let me ask both of you a few questions, if I can.

Ms. Hull, one of the last items you talked about was self-esteem.

Ms. Hull. Yes.

Senator Dodd. I should have pointed out for the record that today you are a registered nurse, you are married, and you have a family.

Ms. Hull. No, I am not married. I have children; I am divorced.

Senator Dodd. Okay. You seem to be a rather confident person. Maybe you have built up a lot of courage to come here. But you strike me as a person who is self assured. As a member of FACES, you have talked about this in the past with other people as well, I presume. This is not your first discussion of what went on in your own childhood, right?

Ms. Hull. Right.

Senator Dodd. How difficult was it for you to talk about it?

Ms. Hull. It is difficult, because even when people I know ask me about it, I do not want to talk about it, and many times when people ask, I kind of gloss over it and change the subject. It took a lot for me to come here today.

Senator Dodd. Well, it seems to me that is one of the problems we face. You may recall a few years ago, at a Children's Caucus hearing, that a former colleague of mine, Senator Paula Hawkins, discussed that she in fact had been a subject of either abuse or potential abuse as a child—I forget exactly which. It brought a great deal of national attention to the issue when she took that courageous step to talk about it.

What do you think we might do to get other people to come forward? I think it is extremely important that adults like yourself who have been through that are willing to step forward. We rely tremendously on professional people who have studied the issue, and they are of tremendous help to us. But I think, in terms of building a base of support in the country with people who are not as familiar with it, it is going to be extremely important that survivors of child abuse come forward to talk about it, make suggestions, and give us some sense of what their lives were like.

I wonder if you have any thoughts at all on how we might best do that?

Ms. Hull. Well, if I had known that people wanted to know, I would have said something previous to this. Just keep saying what you are saying now; say it on a national level, that you want testimony.

I wish I had had more time to prepare it; I only had a week and a half. I could have said a lot more, you know.

Also, make it safe for people to talk about these situations. Make it safe for the families to talk about it, through outreach programs, I guess, by the States. It is kind of a difficult question to answer.

Senator **Dodd**. I understand FACES, the organization you are with, is of some help.

Ms. **Hull**. Yes. It has been a lot of help to me. But do you know it is hard for us to get members for FACES, because many times people do not know that they have been abused.

Everyone in my group is in therapy on the outside with a therapist.

Senator **Dodd**. Does your employer know that you are a member of FACES? Does your employer know that you are a survivor of child abuse?

Ms. **Hull**. One of them does. I work for two agencies, and I did talk about it with one person in one of the agencies. I do not know if she told other people or not. It does not matter to me if she does.

Senator **Dodd**. I suspect if they do not know by now, they are going to know today.

Ms. **Hull**. Yes. I have had jobs where I did not tell anybody, and I kind of regret not saying anything.

Senator **Dodd**. What will happen, do you think? Do you think there is a problem with employees——

Ms. **Hull**. With other employees?

Senator **Dodd**. Well, just in work situations. I mean, do you anticipate that one of the reasons for reluctance to step forward is job discrimination?

Ms. **Hull**. It could be.

Senator **Dodd**. Have you found that to be the case with people you have talked to about this before?

Ms. **Hull**. I heard of one case where that happened. I read a book about a guy who was looking for a governess for his child, and he talked with a few people, and one of them happened to mention that she had been abused. And he thought that she would be a good candidate for this job, except for that one thing. You know, it is like you are abused when you are a child, and it continues when you are an adult.

Senator **Dodd**. Well, there are statistics—in fact, there are incredible statistics—that an overwhelming number of those who serve in our prison system have been abused children, or abusers have been abused children. That is a problem, isn't it?

Ms. **Hull**. Yes, I suppose. But she was good in every other way. I mean, he interviewed her, and he was very pleased with her and wanted to hire her. So she presented herself quite well.

Senator **Dodd**. Okay. There was a piece in the Connecticut Magazine—are you familiar with this?

Ms. **Hull**. Oh, yes, I read it.

Senator **Dodd**. I thought you might have. Let me just get it here. It is the Dale Lyn Crenshaw case. Have you got a copy of it there?

Ms. **Hull**. No.

Senator **Dodd**. And I will submit part of this for the record. It is entitled, "Dale Lyn Crenshaw, Dead by her Father's Hand and the Good Intentions of the State." Just briefly, this was a case in Connecticut where the child service agency workers had been involved in this case and were aware of the dangers. But because of some bureaucratic problems, no action was taken and of course, this infant died.

Do you want to tell us a little more about it, just briefly?

Ms. **Hull**. Well, I guess she had been removed and put in foster care and then went back with her parents. And her father did subsequently kill her. I guess—if I remember correctly, people were supposed to come to the home and see her or something, and then she just was not home, and they could not find her, and they just kind of forget about her, and then she showed up dead.

But my opinion is that kids who are removed from their homes because of documented medical injuries should only be returned very, very judiciously, you see. There should be almost a guarantee that it will not happen again. And the reason is this. People who need help and assertively seek help take years to help themselves and change their problems. How can someone who has had a child removed for abuse, for multiple injuries, how can that kind of person change that quickly, so six months later, after some help that has been almost forced upon then, how can they change enough so that they are not going to do it again? Are their lives going to change that much? No.

So I do not really believe they should be returned to their families. You know, I am not talking about custody battles, where people falsely accuse one another of abusing children. I am talking about medically, documented cases.

Senator **Dodd**. That is a good note to turn to Dr. Madanes, because one of the points in your testimony is that you would like to see more of an effort to keep the nuclear family together. To the extent that families exist, you feel that more efforts ought to be made to keep them together. I should add, if I understand you correctly, that you recognize that in certain cases where that is not going to work, you have to seek other alternatives. But you do emphasize the importance, of retaining that family structure to the extent it exists.

Dr. **Madanes**. I think it is very important not to confuse the issue. The effort should be in protecting the child, not in saving the family. And so even though it is important to find one responsible caring adult with whom the child has a longstanding bond, it is more important to save the life of the child.

Senator **Dodd**. I understand.

Dr. **Madanes**. So my emphasis has been in looking to grandparents, aunts, uncles and the extended network to help in protecting the child.

In the case of that baby in the magazine article that you were showing, the grandmother was concerned; she reported the situation several times. The aunt was concerned. They were never involved. The child was placed in a foster home instead of with the relatives that loved her.

Senator **Dodd**. Well, there is a quote in that magazine which I will read for the record because it is one of the things that stands out in the story. It says,

> Perversely, the more the system tried to protect Dale Lyn and help her parents, the more it isolated them. In fact, branded abusive or incompetent, the parents withdrew from family and friends or were rejected by them. In the end, it seemed

that their only visitors were official ones, and for them the parents were on their best behavior.

I wonder if you might comment on that?

Dr. **Madanes**. Any half-competent professional would have predicted that that man was going to harm that child, and he should have been isolated from the mother and child, and he should have been treated. And what happens is that we just have very incompetent professionals dealing with these cases, and it is shameful. It should be the best professionals in this country that should be protecting the children.

Senator **Dodd**. My next question for you is exactly that—how difficult is it to train people? How much training is needed? What sort of time would you need? How would you design a training program for caseworkers, assuming you would not have an overburdensome number of caseworkers?

Dr. **Madanes**. We need to train people with a master's degree preferable; in some rural areas, we can settle for less than that. And after a person has a master's degree in social work or in counseling or a related area—nursing, perhaps, or whatever—a year or two at the most of training would suffice, probably just a year of intensive family therapy training, and they could detect, diagnose and treat and protect the children.

Senator **Dodd**. The Children's Defense Fund has reported in their budget book that less than 20 percent of the troubled children in families in many States who needed treatment services received them last year. In your experience at the Institute, how accurate an estimate do you think that is?

Dr. **Madanes**. I am sure it is accurate.

Senator **Dodd**. What services are provided for families where there has been a child abuse fatality? What happens in the follow-up?

Dr. **Madanes**. Very often, it is a very untrained, unskilled and unqualified worker who visits the home once in a while and is overwhelmed by the situation in the home, and very often just chats with the mother and is afraid of the abuser in the family. So very little or nothing is done—a perfunctory visit to the home.

Senator **Dodd**. And as you say, they usually will avoid contact with the abuser?

Dr. **Madanes**. With the principal, that is right. They will commiserate, for example, with the wife or the woman in the situation about the violence of the man in the family, and that is it. And this can be solved. There is no mystery about it. It is not difficult. It really is an easy problem to solve.

Senator **Dodd**. I do not know if you would have the number onhand, but what percentage of caseworkers would you guess are male in the country?

Dr. **Madanes**. Given my experience in training groups of people, I would suspect less than 20 percent, maybe 10 percent, 15 percent—but that is a guess.

Senator **Dodd**. Given the fact that in so many cases we are talking about the male sibling, the father, or uncles and so forth, as the abusers, would you recommend that we make more of an effort to attract men to the profession and the training? This is not to the exclusion of women, obviously.

Dr. **Madanes**. It would be nice, but women can be tough too.

Senator **Dodd**. Oh, I was not saying that, believe me. I know the issue. But I mean just in terms of relating to people, sometimes women can be far more effective in helping other to women with various sets of problems. I wonder if you think it might be easier in some cases for men to relate to the male abusers.

Dr. **Madanes**. It could be. I think that women professionals can be trained to find competent, responsible men in the families that they are working with so that a competent male from the family will supplement the female caseworker and will provide that thread——

Senator **Dodd**. I see I am not going to win this argument.

Let me turn to my colleague from Mississippi, Senator Cochran. Thank you for being here.

Senator **Cochran**. Thank you, Mr. Chairman. Let me commend you for convening this hearing and reviewing some of the information that is available to our Committee on the subject of child abuse and neglect.

This is a very important issue and area to explore. We have seen just in the past several days, new reports about teenage suicide, about cases of child abuse and neglect which are very worrisome and which I think point up the fact that we do need to seriously consider the reauthorization of the Child Abuse Prevention and Treatment Act of 1974.

This afternoon, obviously, we are going to have the benefit of testimony from a group of experts, professionals and those who have personal experience in dealing with these problems, and I know we are going to find that to be very helpful and beneficial to us.

I wish that I could remain for the entire hearing. I have an obligation to chair another committee hearing at 3:00, but I am glad to have a chance to come by and look at some of the statements and to thank the witnesses who are here and express my appreciation for your help to this Subcommittee.

Thank you, Mr. Chairman.

Senator **Dodd**. Thank you very much, Senator, and we appreciate your concern and interest in the subject matter as well.

We thank both of you for being here today. We may have some additional questions from other Members as we get closer to reauthorizing the child abuse legislation. This may be particularly true in your case, Dr. Madanes, where your hands-on experience locally may be of some real value and assistance to Members of the Subcommittee and the Full Committee. So we thank you for being here.

Linda, we thank you for coming down. It is a long trip, I know, to come here, and it took some courage to do what you did this afternoon. I want you to know that, as your Senator, I am deeply appreciative of your willingness to step forward. It is not an easy thing to do—and to talk about that experience. It took an awful lot of courage. And an awful lot of people who are not in this room here today, whose names we will never know and whose faces we will never see, thank you as well for saying what you did here today. It has been very, very helpful.

Ms. **Hull**. I hope it helps.

Senator **Dodd**. It will help, believe me. Thank you.

Our next panel is a large panel, Thad. We have some five witnesses. And I apologize for lumping everyone together, but I do not know how else to do this without running out of time.

Anne Cohn, who I have already been with earlier today, is here. She is the Executive Director of the National Committee for the Prevention of Child Abuse, located in Chicago, IL. Dr. Cohn has been working in the field of child abuse before even the 1974 legislation was enacted. In addition to having served as the Executive Director of the National Committee for the past six and a half years, she directed the first national evaluation of child abuse treatment programs, and she will focus this morning on the recent work of the National Committee on child deaths.

With her is Shirley Fitz-Ritson, Director of the Division of Child Protective and Preventive Services, South Carolina State Department of Social Services, Columbia, SC. Ms. Fitz-Ritson has been in the field of child abuse and social services for 15 years. In addition to directing the South Carolina Department, she is a professional associate of the private consulting firm, Action for Child Protection. She will testify this afternoon about the problems of front-line protective services workers and the study her department did of child abuse deaths in South Carolina. We thank you for being here with us.

Dr. Larry Aber is Assistant Professor of Psychology at Barnard College and Director of the Center for Toddler Development in New York. Dr. Aber used to be a constituent of mine, I should say, having earned his degree under Ed Ziegler at Yale in Connecticut. He is an active researcher, focusing on the development of children at risk, including abused children. He has held grants from the National Center of Child Abuse and Neglect, the National Institute of Mental Health and private foundations. He has also worked directly on providing services for children, some of whom are the victims of abuse and neglect. And he has worked on policy, having served in the Dukakis administration in the State of Massachusetts. So he comes to us this afternoon having worn many hats in this area, and we are delighted you are with us, Dr. Aber.

Jay Whitworth is also a physician and Medical Director of the State Child Protective Services Team, the American Academy of Pediatrics Task Force in Child Abuse, from Tallahassee, FL. In addition to representing the State of Florida in the American Academy of Pediatrics, Dr. Whitworth is an Associate Professor of Pediatrics at the University of Florida. He will outline for us procedures used in his home State to train medical examiners so child abuse deaths will be reported. And lastly he will comment on the role of pediatricians in the child abuse field.

And lastly, we have Jim Hollihan, Director of Program Services, United Cerebral Palsy Association, Consortium for Citizens with Developmental Disabilities here in Washington. By representing the United Cerebral Palsy Association and the Consortium for Citizens with Developmental Disabilities, Jim Hollihan will be addressing the special risks of abuse and neglect faced by disabled children. And we thank you as well for being with us today.

We will begin with you, Anne, if we can. We were with each other this morning at our press conference on child abuse prevention, and I thank you for being here this afternoon.

I would just say the same would apply to everybody here as far as your statements go. I would encourage you to be brief so we can finish with all the witnesses this afternoon. Everything that you have in printed form will be made a part of the record. If you would care to paraphrase it or however you want to proceed, we would be glad to accept your testimony accordingly. And we thank you again for being here.

Dr. Cohn.

STATEMENTS OF DR. ANNE COHN, EXECUTIVE DIRECTOR, NATIONAL COMMITTEE FOR THE PREVENTION OF CHILD ABUSE, CHICAGO, IL; SHIRLEY FITZ-RITSON, DIRECTOR, DIVISION OF CHILD PROTECTIVE AND PREVENTIVE SERVICES, SOUTH CAROLINA STATE DEPARTMENT OF SOCIAL SERVICES, COLUMBIA, SC; DR. J. LAWRENCE ABER, ASSISTANT PROFESSOR OF PSYCHOLOGY, BARNARD COLLEGE, AND DIRECTOR, CENTER FOR TODDLER DEVELOPMENT, NEW YORK, NY; DR. JAY WHITWORTH, MEDICAL DIRECTOR, STATE CHILD PROTECTIVE SERVICES TEAM, AMERICAN ACADEMY OF PEDIATRICS TASK FORCE ON CHILD ABUSE, TALLAHASSEE, FL; AND JIM HOLLIHAN, DIRECTOR OF PROGRAM SERVICES, UNITED CEREBRAL PALSY ASSOCIATION, CONSORTIUM FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES, WASHINGTON, DC

Dr. COHN. Thank you, Senator Dodd, Senator Cochran.

It is my pleasure to present testimony to you related to the reauthorization of the Federal Child Abuse and Neglect Treatment Act of 1974.

Senator DODD. You can comment on my other bill, too, if you would like.

Dr. COHN. And your bill, which I will comment on in a moment.

I have long been a supporter of this Federal Act and the National Center on Child Abuse and Neglect, which it created. I think there remains a tremendous need for this particular Federal program, and I also believe that there are very important ways in which we can improve that Federal program.

What I would like to address today are two different things—first, an indication of why I think there is a remaining and significant need for the Federal program, which relates to increases in child abuse deaths; and second, why I think there is a need for improvement in this particular Federal program, particularly in the area of leadership and planning.

First, let me talk about child abuse deaths. Every six months or so, the National Committee for Prevention of Child Abuse conducts a study of all 50 States to see what is going on with reports of child abuse and other related matters. This fall, we began to learn from various States that there was a significant increase in child abuse deaths, at least in their particular jurisdiction. Most notably, we learned in the State of Illinois, the death rate had increased over 40 percent between 1985 and 1986. In fact, our local CBS affiliate did a detailed investigative report on a number of child abuse deaths. Pam Zeckman, the investigative reporter, pointed out how handling of these cases by the Children's Protective Service Agency and the community in general contributed significantly to these tragic deaths.

We wanted to learn whether or not these child abuse deaths and their increase was a national phenomenon, so we decided to follow up with all 50 States. We attempted to gather data for 1984, 1985 and 1986. Preliminary data which we released in January from 24 States in fact showed that there had been a significant increase. By mid-March, we had gathered data from 34 States and perfected some of the data we had earlier gathered. As you know, 10 States do not gather child abuse death data, and others take more time to pull together their data at year-end.

What the data showed us for 34 States is that there were 727 deaths. Projected nationally, this is about 1,200 deaths. We considered this to be a very conservative estimate, because many States only count as child abuse deaths deaths of children who happen to be within the Children's Protective Service Agency caseload, and many deaths occur out of that caseload. And also a large number of child abuse deaths get labelled as SIDS deaths or other kinds of accidental deaths as well.

This particular number, over 1,200 cases, represents what we now project to be a 23 percent increase between 1985 and 1986. We think this is a very significant increase, and we were interested in knowing a little bit more about it.

One of the things we wanted to know, even though it is very similar to the increase in homicide rates seen in nine out of the ten major cities across the country, is if this increase is in fact a reflection of the fact that States are just counting better how many deaths there are. So we invited all the States and a number of national organizations to come together in Washington a few weeks ago to address this question.

Regrettably, what we learned from the States who were there is that the increase in child abuse deaths is indeed a real increase, as best they can tell. While a few States have dramatically changed their recordkeeping procedures, in general, States have not done that.

What the States have indicated is that there are a number of other causes that would account for this dramatic increase. A series of social problems—the increased number, for example, of teenage mothers who are unwed, who are living in what one might refer to as the underclass—the increased use of drugs—crack, for example, in New York City—and a number of other social problems that just contribute to an environment in which child abuse is more likely to lead to death is more likely.

Second, what is going on with the children's protective service system. With the dramatic increase in reports over the last decade and even over the last three or four years, there has not been a dramatic increase in funding for these agencies. What we find is that CPS agencies are overburdened, overwhelmed, workers have way more cases than they can handle. And in general, even when cases are reported and opened up for treatment because one can confirm that child abuse occurs, families are receiving no treatment. So even though treatment might have helped, no treatment is provided, and child abuse deaths occur.

And finally, there appear to be problems in the community in general. There are very few preventive services available for families and very little coordination among those different agencies in the community that support families.

It seems clear that there is much we should be doing about child abuse deaths. We are greatly concerned about this increase. So are the States that we talked to. The concern was so great that we have agreed to convene the States as well as various researchers across the country who have been looking at this issue, sometime within the next four months, to take a longer and more in-depth look at this whole issue of child abuse deaths: why is it increasing, what can we do about it, and specifically what can children's protective service agencies do, since they are the agency in each State designated as being responsible for this particular problem.

One of the things that is clear to us as we look upon this conference and the kinds of outcomes it may have is that there is a tremendous need for better gathering of data at the national level. And I would like to commend you, Senator, for the bill that you have introduced to establish a commission at the national level. It is obviously not possible today to state exactly how many children are dying as a result of child abuse, and a number of other kinds of problems and difficulties, and that information would be crucial in efforts to solve the problems.

There is a need for better data. Data on deaths should be gathered by all States; it is not. That data should be standard from one State to another; it is not. And that data in fact should be assembled at the national level.

In my opinion, this is a logical role for the Federal Government. Unfortunately, the National Center on Child Abuse and Neglect, which is the logical Federal agency to gather this data, does not do that right now. Even though for the last decade they have been funding a national reporting study that gathers information from across the country on how many reports of child abuse there are, that study does not gather information on child abuse deaths. And in fact, most recently, in the last year, that study has been cut back dramatically so that a study which at one time was able to gather information from all 50 States and do some detailed analysis now only has funding to gather information from 5 States and do a detailed analysis.

Detailed analyses of reporting data from 5 States is inadequate to look at trends nationally and know what is going on. To me, this is one indication of the lack of leadership at the Federal level and lack of leadership coming out of the National Center on Child Abuse and Neglect, and I would like to turn my attention to that for just a few moments.

To me, the National Center on Child Abuse and Neglect is the only opportunity we have at the national level to address the issue of child abuse. Obviously, the National Center on Child Abuse thus should be a leader, a catalyst; it should be working with the field and building upon the resources that exist.

I think the time of reauthorization is a good time to look and see whether or not this is happening—and in my opinion, it is not happening. I have outlined a number of concerns I have in my written testimony. Let me just cite a few of them right now.

First, I think the National Center on Child Abuse and Neglect makes inadequate use of the research findings that it generates through its studies. For example, several hundred demonstration programs have been funded by the National Center on Child Abuse and Neglect in the last decade. Over 80 of those have been subjected to detailed evaluation studies of over three years or longer. More than $40 million has been spent by the National Center on demonstration programs and on the evaluations done in those studies. There are very interesting findings that come out of those studies. The findings are consistent over time. The findings would be useful for children's protective service agencies in perfecting the way in which they do treatment, and the findings lead to logical additional pieces of research, and the findings suggest ways in which we can in fact study this problem better.

It seems logical to me that the National Center on Child Abuse and Neglect would make these findings and the methodologies used readily available to the field and regularly available to the field so that as researchers get involved in this area, they can perfect the methodologies and build on the research findings.

Second, inadequate conference planning. The National Center on Child Abuse and Neglect has now sponsored seven national conferences. They have been held every year or two. These national conferences have become the single forum in the field for people from across the country, from all disciplines, to come together, share new research, learn from each other and essentially find out what is going on in the field. In a field that is as rapidly changing as this, that particular forum is tremendously important.

The last conference was held a year and a half ago. As best I know, no specific data has been set for the next conference. Despite the fact that the private sector has offered to plan this conference and has offered to plan it with no Federal funds, the National Center has held onto this responsibility, but has failed to execute it in a timely manner.

At a time when there is such dramatic change in our knowledge and in practice in the field, it seems to me that this conference must be scheduled and must be held. Or perhaps the National Center should consider turning the responsibility for this over to the private sector.

Third, inadequate publicity about the National Center's Clearinghouse. For almost a decade now, the National Center has put millions of dollars into a National Clearinghouse on Child Abuse and Neglect. That Clearinghouse maintains computerized information on not only research that has been done in the field, but a whole host of other important issues—literature that has come out, and so on.

Unfortunately, not enough people in the field know that Clearinghouse exists, so not enough of the professionals working in the field make use of that Clearinghouse. One of the most significant reasons for this is that the Federal Government, for whatever reasons, has not publicized the existence and the availability of the Clearinghouse. It seems to me that the National Center should publicize this Clearinghouse, and if there are Federal regulations that prohibit them from doing that, then they ought to perhaps turn to some of the private agencies that are acting in this field and ask them if they would help out. I am certain that they in fact would.

Finally, inadequate support of the National Center's staff. The staff of the National Center on Child Abuse and Neglect can only rarely, as I understand it, travel, attend conferences, educate themselves, and essentially keep up with what is going on in the field. As I mentioned, this is a fast-moving, rapidly changing area. You cannot be as isolated and as removed from the field as the National Center staff are and provide any guidance and any leadership. I think it should be a priority for the National Center to make sure that the staff is fully up-to-date on what is going on in the field so that they in fact can be experts that the field would turn to for advice and guidance.

These are just a few of my concerns. Underlining these concerns is my belief that there needs to be much stronger leadership from the National Center on Child Abuse and Neglect. Much needs to be done to assure that there is this kind of leadership. I think there is a need for improved visibility of the National Center, perhaps by changing where it sits within the Federal bureaucracy. There is a need for people in the field to have much greater input into what the National Center is doing and create more of a dialogue with what is going on. And third, and perhaps most significantly, there is a need for some kind of long-range planning. Each year, the National Center spends many millions of dollars on various kinds of research and demonstration programs. But those priorities from year to year are not necessarily part of any kind of long-range plan.

I would urge that as we look at the reauthorization of the Federal Child Abuse Act we look at ways in which NCCAN can do some long-range planning. We should look at what it is NCCAN should accomplish over the next four or five years so as NCCAN sets about its year to year priorities, it can do so with a sense of some direction and a sense of what it would like to accomplish.

Thank you.

[The prepared statement of Dr. Cohn, with accompanying material, follows:]

TESTIMONY

Presented Before The
Senate Subcommittee on Children, Families,
Drugs and Alcohol

By Anne H. Cohn, D.P.H.
National Committee for Prevention of Child Abuse

I am pleased to present testimony which I hope will lead to the reauthorization of the Child Abuse Prevention and Treatment Act of 1974 and to the strengthening of the National Center on Child Abuse and Neglect (NCCAN). When the Act was first passed in 1974, little was known about the child abuse problem. In fact, at Congressional hearings leading to the enactment of the Child Abuse Act, the late Dr. C. Henry Kempe testified that there could be as many as 60,000 cases of child abuse. We now know the number of cases annually -- even at that time -- to be closer to one million. At that time an estimated 1 out of 10 adults had heard of the child abuse and neglect problem. Today, essentially all adults have heard of the problem, are concerned and want to do something about it. In the short 13 years since the federal government shone a spotlight on the child abuse problem much has happened:

- a cadre of thousands of professionals from law enforcement, social work, medicine, public health, psychology and other fields have become actively involved
- state children's protective service agencies have developed systems for identification, diagnosis and treatment of cases.
- we have a better idea of the size of the problem

- we know a lot about the underlying causes of the different types of maltreatment
- we have a developing knowledge base about treatment
- we have a sense of promising prevention programs
- prevention activities have exploded -- support programs for new parents, prevention education for elementary school children and the like can be found in every community
- 40 states now have Children's Trust Funds, spurred on by the national matching grant program
- the public have become aware of the problem and the private sector has become involved
- child abuse is recognized as a top social problem: 66% of the public say they as individuals can do things to prevent it; 23% say they did something in the last year.

Much of this progress can be attributed to the existence of a federal child abuse program. However, despite all this progress, we face a number of significant problems:

- the Child Protection Service (CPS) system in many locations is in a state of what I would call collapse -- significant numbers of cases diagnosed as child abuse, for example, are opened up for treatment and never receive any and serious reabuse occurs
- there are no standards or generally accepted principles of practice; as a result investigative, diagnostic and treatment practices across the country are quite inconsistent

- we still know very little about the long term effects of treatment and prevention strategies
- what we do know through research to date is poorly communicated to the field, and thus, rarely used
- there does not appear to be any reduction in the amount of child abuse and indeed, the number of deaths due to child abuse appear to be increasing
- and, there is no clear leadership for the field, from the federal government and there is little partnership between the federal government and the rest of the field.

Today I would like to address the last two of these concerns: the increase in child abuse related deaths and the lack of federal leadership and partnership in this field.

Increase in Child Abuse Deaths

Since 1982, the National Committee for Prevention of Child Abuse (NCPCA) has conducted a semi-annual fifty state survey in order to monitor trends in the number and characteristics of child abuse reports nationwide and in the funding and scope of child welfare services. Twice a year, the federal government's liaison officer for child abuse and neglect in each state is contacted by telephone and asked a series of questions with respect to child abuse reports as well as other issues of concern to the field. In our most recent round of telephone calls to the states, we gathered, among other things, information on reports of child abuse-related deaths during 1986. (The detailed study report which delineates the methodology and findings is attached.)

By March, 1987, 34 states were able to provide actual comparable figures for 1985 and 1986 with respect to reports of child abuse-related deaths. Overall, for these 34 states, 727 children were reported dead as a result of child abuse; this represents a 23% increase between 1985 and 1986. (A report released by NCPCA earlier this year cited an increase of 29% based on 24 states.) We now project at least 1,200 children died last year as a result of maltreatment. The actual number could exceed this projection, given that (a) a number of states only count those deaths which occur in cases being handled by the Child Protective Service agency and, (b) a number of child abuse-related deaths are not reported as such but are labeled as sudden infant death syndrome (SIDS) or some other category.

Approximately half of the fatalities involved physical abuse. In some instances, death was the cumulative result of repeated, severe beatings while in other cases death resulted from a single violent episode. The other half of the victims died as a result of child neglect, most often because parents failed to provide adequate supervision. While we do not have detailed data on those children who died in 1986, studies suggest at most 75% of the victims of child abuse deaths are one year or younger, and they are more likely children of younger caretakers.

Although only an estimate, we felt that the magnitude of this increase was striking enough to warrant serious attention. Of course, of initial concern was whether this increase may reflect a more accurate reporting system. While the increase is consistent with current trends in infant mortality rates and levels of serious family violence and violent crimes, we felt it would be important to know what the states felt the cause of the increase was -- better record keeping or other social or systems problems. To this end, on March 19, 1987 we held a meeting in Washington, D.C. to discuss the reported increase in the number of child abuse fatalities. Representatives from all fifty states were invited to attend.[1] According to the individuals present at the meeting, (and the states with the most significant increases were present) the increase cannot be attributed solely to more accurate identification systems. Most of the states reported that their statutes pertaining to the identification of fatalities have been in place for a number of years. And the numbers remain under counts of child abuse deaths in part because some unknown number of child abuse deaths get labeled as SIDS cases. Therefore, with a few notable exceptions, these numbers regrettably reflect an actual increase in the number of children dying as a result of maltreatment.

With a consensus on the reality of this statistic, the group identified some of the underlying causes contributing to the increase in child fatalities. Three major themes were evident among the reasons for the increase: (1) growing social problems, (2) problems within the current child protective service structure, and (3) the lack of a coordinated effort among the other systems dealing with children.

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[1]. States and organizations sending representatives included: California, Connecticut, Delaware, Georgia, Illinois, Maryland, Massachusetts, Minnesota, Missouri, Montana, New Jersey, Pennsylvania, South Carolina, Texas, Utah, West Virginia, American Humane Association, Child Welfare League of America, National Association of Public Child Welfare Administrators (APWA), National Association of Social Workers, Parents Anonymous, National Child Abuse Coalition and National Committee for Prevention of Child Abuse.

Several of the state representatives, particularly those from the nation's largest urban areas, indicated that growing drug problems, higher rates of teenage pregnancy, and poverty in general appear to have contributed to an increase in child deaths due to maltreatment. States reported seeing a higher number of very severe cases, particularly among families involved in child neglect. While not all states identified teenage parents as being more likely than older parents to harm their children, the limited resources in single parent, female headed households appear to contribute to a higher risk that the child may experience serious harm. Also, households which have a number of adults moving in and out present more volatile and potentially dangerous situations for children.

Outside of these social issues, the shortcomings within the child protective service agencies may also contribute to an increase in certain deaths.[2] Participants cited an inadequate level of available resources, resulting in the number of child protection workers being too small to handle the volume of reported cases. Overburdened with heavy caseloads, the workers devote so much time to the initial investigations that they are unable to adequately follow-up and monitor families once they are on the caseload. When families are identified and labeled as abusive and do not receive direct services, the children become even more vulnerable. Because of the unusually high turnover rate among child protective service workers, caseworkers are responding to reports without having been given sufficient training in crisis intervention. Neither schools of social work nor CPS agencies have taken the initiative to provide the workers with the skills necessary to be effective child protective service workers. It is also important to point out that some number of the child abuse deaths occur in the very foster homes a child has placed for child protection.

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[2]. It is important to note that between 25% to 50% of child abuse deaths involve children reported to local children's protective service agencies prior to their death.

However, even perfectly trained CPS workers cannot manage their cases effectively unless they have all the background information they need and all the service support their caseloads require. The failure to interpret child protection as a community problem and a shared responsibility was another problem discussed at the meeting. The lack of a coordinated effort among law enforcement, juvenile court judges, medical professionals, coroners, and other public health officials necessitates CPS workers having to make decisions without all the facts. By failing to respond or offer help initially, these professionals as well as members of the community do not leave time for the protective service agency to adequately deal with their cases.

A number of crucial issues emerged from the discussion which must be addressed by individual states and the field in general:

- How to achieve better, more coordinated nation-wide data collection which reflects the total number of deaths including those now counted as SIDS deaths or those not counted at all.
- How to facilitate obtaining and monitoring the details surrounding a child's death so we can learn more about prevention.
- How to educate the public on the severity and impact of child neglect as well as physical abuse as triggers of child abuse deaths.
- How to provide better training and working conditions for CPS workers to avert child abuse deaths.
- How to put into place an improved diagnosis and screening system to assure that families at risk do get support.
- How to encourage and train social work students to go into the field of child abuse prevention and treatment.
- How to best apply permanency planning guidelines in reducing a child's risk for serious abuse.
- How to plan and implement an expanded child protection system which involves the community in preventive activities.

Consensus at this meeting was that we need a national gathering soon of all 50 states and those studying child abuse deaths to spend more time pooling our knowledge and identifying solutions to the above. The National Committee for Prevention of

Child Abuse along with other members of the National Child Abuse Coalition will hold such a meeting within the next four months.

There is tremendous enthusiasm from the states and a number of private agencies for the action now being taken with respect to child abuse deaths. Collectively, I believe that there is a sense of relief that we are finally addressing this issue as both a state and a national concern.

Lack of Leadership From the Federal Government

I have always been a strong supporter of the existence of a National Center for Child Abuse and Neglect within the federal government. NCCAN is the only opportunity the federal government has to address the issue of child abuse directly. Happily, the legislation creating NCCAN is currently crafted in such a way to allow NCCAN the flexibility to address the range of issues of high importance which arise in this field from year to year. Given the importance of the issue of child abuse and the relatively small amount of funds NCCAN has at its disposal, NCCAN must operate as effectively as possible, building on and working with other resources which exist in the field.

It seems to me that, given the complexity of the problem and the variety of professions, agencies and interests involved, NCCAN should play a leadership role, it should be a catalyst, a beacon for action in this field. It is not that NCCAN should be making decisions for the field or even necessarily espousing specific positions on issues. Rather, NCCAN as a leader should facilitate decision making and discussion of issues. And NCCAN should be an active partner with the field in a variety of critical activities. Such has not, in my opinion, been the case in the last several years since the Child Abuse Act was last reauthorized. There has been a noticeable lack of leadership from NCCAN and there has been a lack of opportunities for input into NCCAN's activities from the field at large. In fact, at this moment there is no permanent Director of NCCAN. The Director has been detailed for 3-9 months to a special project within the Department but away from child abuse responsibilities. And, NCCAN's National Advisory Board -- a key vehicle for input from the private sector -- meets once and at most twice a year. I would like to share with you my biggest concerns with the hope that as we look at the reauthorization and continuation of this program, we can look at ways of improving performance. In doing so, I would like to recognize that it is easy to sit outside of NCCAN and flag problems. Without seeming unduly critical, perhaps a time of reauthorization is a time to for the field to reflect on problems which can be identified -- and offer solutions. The following points cover a range of concerns I have and how I think they can be dealt with.

- Inadequate use of research findings (such as the evaluation studies of treatment programs): Since 1974, NCCAN has funded several hundred demonstration treatment programs. Over 80 of them have been subject to extensive evaluation. The findings across studies are consistent and useful. This is just one example of research findings gathered by NCCAN. And, as with most research findings, NCCAN has never made use of them.

The findings from these studies are logical leads for subsequent studies in the field. And states and local treatment facilities would benefit from knowing the conclusions of this work which NCCAN spent over $40 million on. NCCAN should make the findings from these and other research and evaluation projects funded by NCCAN readily and regularly available to the field.

- Inadequate research on prevention strategies: Although the most recent reauthorization of the federal Child Abuse Act called for significant funds to be put into prevention, relatively little has been. There have been too few studies on the outcomes of prevention efforts -- those for parents as well as those for children. There have been too little research on the relative benefits of intervening with high risk families rather than those who have already been abused. Given what we know about the relative ineffectiveness of treatment programs, it is essential that we explore preventive solutions. NCCAN should establish a prevention research agenda and pursue it.
- Inadequate attention to the development of standards in the field: currently several different national organizations are setting about to develop standards of practice for their particular constituency in the field. Even the U.S. Surgeon General is working on the development of protocols for the field. The field has much to gain if these efforts were coordinated. NCCAN should be helping to do so.

- Inadequate attention to the collapse of CPS: As reports of child abuse have climbed during the last decade, funding for Children's Protective Services has not increased at the same rate. Consequently, CPS systems, particularly those in urban areas, appear overburdened, overwhelmed and essentially on the verge of collapse. Many states have established task forces to respond to this problem. Some national organizations, such as the American Public Welfare Association, has gotten involved as well. NCCAN should be helping to lead these efforts, minimally facilitating communication among the various groups struggling with this problem. NCCAN should be a resource the states can draw on.
- Inadequate planning for the field's only national conference: NCCAN has sponsored seven national conferences. Held every year or two, these conferences have become the one national forum for the field to get together, share new research and clinical information and take stock of where we are going. The last conference was held almost one and one-half years ago. The field is unaware of any date that has been set for the next conference. Despite the fact that the private sector has offered to plan this conference -- with no federal funds -- NCCAN has held on to the responsibility but has failed to execute it in a timely manner. At a time when knowledge and practice is changing rapidly, the field loses out. Dates and locations for conferences to be held at regular intervals for the next 6-8 years should be set now;

NCCAN should give serious consideration to turning this function over to the private sector.

- Inadequate publicity of NCCAN's Clearinghouse: NCCAN has put literally millions of dollars into the development and maintenance of a clearinghouse on child abuse and neglect. The Clearinghouse features a computerized data base on key literature in the field and other important information. The only problem is few professionals working in the field know of the existence or capacity of the Clearinghouse because it is not allowed to publicize itself. If professionals in the field do not know about the Clearinghouse, not only do they fail to use it, but they also do not let it know about their own work, which makes the clearinghouse incomplete. Efforts should be made to publicize the Clearinghouse capability. If federal regulations preclude NCCAN from doing so, NCCAN should request, and will certainly secure, complementary assistance from private organizations in the field.
- Inadequate support of staff: The people who work within NCCAN have not been allowed to become professionals in the field. They are not allowed to travel, to go to conferences, to educate themselves about what's going on. This is a fast moving, rapidly changing field. You can not be as isolated or removed from the field as the NCCAN staff are, and provide any guidance or leadership to the field. A priority for NCCAN should be for its staff to be fully up-to-date on

developments in the field, to be, in fact, experts to whom the field would turn.

- Inadequate funding of the only national data base: For a decade now, NCCAN has funded a national reporting data study which gathers information on child abuse reports from all 50 states. This is the only national data base in the field. Although not a perfect data base, it does provide important trend information on the types of child abuse cases being handled nationwide. In the past year, NCCAN cut the funding of this national data gathering effort substantially. The result? The study may now only analyze data in depth from a maximum of five states. Such analyses have little utility. If anything, this is a study which should receive more funding so that it can work on perfecting its weaknesses and it could, for example, gather data nationally on child abuse-related deaths. The federal government in other areas has long played a role in measuring society's economic, social and health well being. So too must it be the case with child abuse. A million dollar incidence study funded by NCCAN every 5-10 years is important, too. But, it must not take the place of this trends data. The solution, clearly, is for NCCAN to reinstate full funding for this study and put energy behind making this study as useful as possible.

Correcting these areas of concern will result in a National Center which better serves the field. But more needs to be done.

As we look at NCCAN's performance since the last reauthorization, certain needs are clear:

- the need to improve the visibility of NCCAN not only within the federal government but nationally as well;
- the need to expand opportunities for the field to advise NCCAN on the directions it should take and to work in partnership with NCCAN; and
- the need to reinvigorate the leadership NCCAN offers the field.

And, perhaps underlying these, there is a need for NCCAN to do some long range planning, to set an agenda for itself and in turn for the field. NCCAN's programs and priorities from year to year should be related to a long range plan. Annual research and program priorities must not be developed in a vacuum (or in a hurry) as many of us fear they may now be. Research activities, drawn from such a plan, should lead to demonstration programs -- so we can try out the ideas we learn from research. The public's opportunity to comment on annual priorities is very important. Any long range planning NCCAN does, must be done with the field.

Reauthorization Issues

Beyond these concerns, there are some issues basic to the legislation itself which we hope will be addressed during the reauthorization process. The following basic positions have been adopted by the National Child Abuse Coalition, an informal coalition of 25 major national organizations concerned with child abuse. Those positions include:

(1) Extend P.L. 93-247 for an additional five years. (This program has proven its importance; the child abuse problem will not diminish in the near term. With longer term certainty, the program could do separately needed long range planning.)

(2) Increase authorized funding to $50 million for FY 88. (Authorization for FY 87 is at $43.1 and appropriations are at $25.898 million.) Not only should the authorization be increased to reflect the importance of this problem, but the appropriations must be at the full authorization levels.

(3) Amend the grant years limit from three years to five years to promote long-term research. (We remain handicapped by our lack of knowledge about the long term effects of both treatment and prevention programs. Longer term research is essential.)

(4) Do not expand the responsibilities of NCCAN more the definitions of child abuse currently in the law. (NCCAN's responsibilities are already extensive. Successes with the charges NCCAN has will only be possible if NCCAN can remain focused.)

In sum the National Center on Child Abuse and Neglect should be a leader for the field, providing guidance and coordination on issues which emerge in the field while pursuing a thoughtful plan of research and demonstration. The issue of child abuse is too important for the federal government to relegate this program to one of little prominence and low priority. In reauthorizing the Child Abuse Prevention and Treatment Act I hope it will be possible to identify ways to strengthen this essential program. Thank you.

DEATHS DUE TO MALTREATMENT SOAR:

The Results of the Eighth Semi-Annual Fifty State Survey

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Reports of Deaths Due to Maltreatment Soar

OVERVIEW

More than ever, 1986 was a year in which America was confronted with the devastating affects of child abuse and neglect. News reports from across the country uncovered story after story, each one telling us of further hurt and damage being done to children not only by their parents but also by an overburdened and underfunded child welfare system.

The National Committee for Prevention of Child Abuse (NCPCA) and other private child welfare organizations have for over a decade, spearheaded nationwide public education efforts to let people know what they could do about child abuse, how to get help if they were abusing their own children, or how to report suspected maltreatment by others. The results of these efforts are found in widespread public awareness and concern with the problem of child abuse and in the expanded availability of child abuse prevention and treatment services. The results of these efforts are also found in the continuing increase in the reports of maltreatment and the expanding caseloads of child and family service agencies.

Since 1982, NCPCA has conducted a semi-annual fifty state survey in order to monitor trends in the number and characteristics of child abuse reports nationwide and in the funding and scope of child welfare services. Twice a year, the federal government's liaison officer for child abuse and neglect in each state is contacted by telephone and asked a series of questions with respect to child abuse reports as well as other issues of concern to the field.[1] The results of this survey are then compiled by NCPCA staff and disseminated to the general public as well as those working in the field of child abuse treatment and prevention. The purpose of this report is to summarize the results of the most recent survey.

CURRENT SURVEY

In the fall of 1986, NCPCA's Center on Child Abuse Prevention Research conducted the eighth semi-annual survey of child abuse state liaison officers identified by the federal National Center on Child Abuse and Neglect. The primary objectives of this survey were:

- to obtain current statistics on the number and characteristics of child abuse reports for 1985 and 1986;
- to obtain current statistics on the number of deaths due to maltreatment occurring in 1985 and 1986;
- to determine the extent to which federal or state budget cuts have affected child welfare service delivery;
- to determine if significant differences exist in the rate with which certain types of reports are substantiated across and within states; and
- to determine the relative importance of prevention activities within a state and the extent to which explicit funding exists for prevention efforts.

Although representatives of all fifty states and the District of Columbia were contacted, the level of specificity provided varied across respondents. Of those interviewed, 34 respondents knew or were able to project their child abuse reporting statistics and 24 states had statistics with respect to child deaths due to maltreatment for 1984, 1985 and 1986 at the time the survey was conducted. All state representatives responded to general questions about reporting levels, substantiation rates and prevention services.

SPECIFIC FINDINGS

The number of child abuse and neglect reports continued to increase in 1986. Based upon reporting data collected from 33 states and the District of Columbia, an estimated two million reports of maltreatment were made nationwide during the past year, approximately 6% more than had been recorded during 1985. This increase is below the 10% increase between 1984 and 1985 recently reported by the American Association for Protecting Children, a division of American Humane.[2] As summarized in Table 1, differences in the reporting rates continue to vary dramatically among the states, ranging from a 23% decrease in Minnesota to a 20% increase in Alaska and California.

This apparent decline in the rate in which reports of maltreatment are increasing needs to be interpreted cautiously. First, two-thirds of the 1986 figures are projections based on the number of reports received by states during the initial six months of the year. While, on average, reporting during this period tends to mirror the number of reports made in the last six months of a year, a break with this pattern for 1986 is possible. Second, these projections are based on the experiences of 33 states. Although these states represent all

TABLE 1

ACTUAL/PROJECTED PERCENTAGE INCREASE IN REPORTS OF CHILD ABUSE AND NEGLECT FROM 1984-1986

STATE	1984-1985	1985-1986
ALASKA	5%	20%
ARIZONA	23%	12%
ARKANSAS	TRACE	8%
CALIFORNIA	18%	20%
CONNECTICUT	11%	1%
DELAWARE	-17%	10%
DISTRICT OF COLUMBIA	-1%	21%
FLORIDA	15%	9%
GEORGIA	17%	17%
HAWAII	-3%	1%
IDAHO	7%	2%
ILLINOIS	4%	1%
INDIANA	21%	-1%
IOWA	1%	8%
KANSAS	9%	-9%
KENTUCKY	6%	6%
LOUISIANA	36%	-6%
MAINE	8%	5%
MASSACHUSETTS	6%	5%
MINNESOTA	-6%	-23%
MISSISSIPPI	64%	13%
NEBRASKA	30%	-2%
NEVADA	8%	11%
NEW YORK	4%	17%
NORTH DAKOTA	5%	6%
OHIO	35%	6%
OKLAHOMA	12%	9%
OREGON	10%	7%
PENNSYLVANIA	4%	10%
SOUTH CAROLINA	9%	0%
SOUTH DAKOTA	39%	9%
UTAH	17%	3%
WASHINGTON	-5%	9%
WISCONSIN	46%	10%
AVERAGE	13% *	6%

* The American Asociation for Protecting Children found a 10% increase in reports for this period in their detailed analysis of official reporting data from all fifty states.

regions of the country and constitute over 65% of the total potential pool of respondents, the sample is selective. The total reports from all fifty states and the District of Columbia may differ from the two million reports suggested by the survey data.

In contrast to this slow down in the rate of growth for child abuse reports, the number of child deaths due to mmaltreatment increased dramatically in 1986. At the time of the survey, 24 states were able to provide the number of confirmed or suspected deaths due to maltreatment for all or at least half of 1986. These data suggested that the number of confirmed or suspected child deaths due to maltreatment had increased 29% between 1985 and 1986. This increase was in sharp contrast to the experiences of these same 24 states between 1984 and 1985, when the number of child deaths declinded 2%.

Subsequent to the completion of the survey, follow-up telephone calls were made to those states only able to provide projected figures for 1986 or who had not yet compiled state wide data with respect to child deaths. These efforts secured comparable data from 34 states. These data are summarized in Table 2. As this table indicates, the experiences of this enlarged sample were similar to those reported in the initial survey. Overall, the number of deaths due to maltreatment rose 23% between 1985 and 1986.

In 1986, 727 children in our sample 34 states died or were

TABLE 2

Reported Child Deaths Due to Maltreatment

1984 - 1986

	1984	1985	1986
Arkansas	19	9	8
Colorado	20	12	26
Connecticut	5	6	9
Delaware	0	0	2
Hawaii	2	1	1
Idaho	6	2	4
Illinois	54	54	80
Indiana	26	37	42
Iowa	11	9	10
Kansas	5	9	12
Kentucky	22	10	9
Louisiana	25	80	110
Maine	1	0	1
Maryland	15	10	16
Massachusetts	11	13	7
Missouri	31	24	18
Montana	2	3	0
Nebraska	3	4	2
Nevada	3	6	4
New Jersey	21	21	9
New Mexico	5	12	7
New York*	123	106	162
North Carolina	16	8	5
North Dakota	0	0	0
Ohio	--	37	41
Oklahoma	16	16	24
Oregon	3	8	15
Pennsylvania	42	36	44
South Carolina	6	21	22
South Dakota	6	4	2
Utah	5	8	3
Virginia	16	14	14
Wisconsin	8	7	8
Wyoming	0	3	3
TOTAL	528	590	727
Percent Change Between 1984 and 1985		12%	
Percent Change Between 1985 and 1986			23%

*Number Confirmed or Pending

suspected of dying as a result of abuse or neglect. Assuming that these levels hold for the non-reporting states, we project that at least 1,200 children died last year as a result of maltreatment.[3] The actual number of deaths as well as the overall rate of increase could exceed or be less than this projection depending upon the specific performance of each state.[4]

Approximately half of these fatalities involved physical abuse. In some instances, death was the cumulative result of repeated, severe beatings while in other cases death resulted from a single, violent episode. The other half of the victims died as a result of child neglect in which the parents failed to secure needed medical care or failed to provide adequate supervision. While the responding states were unable to provide specific descriptions of these victims, individual county and state surveys suggest that very young children are most vulnerable. Recent surveys of suspected child abuse deaths in Los Angeles County and the State of Illinois, for example, have found that almost 75% of the victims were one year or younger.[5] Comparisons of reported child abuse fatalities to those children reported for non-fatal abuse in one state found that children who die as a result of maltreatment are more likely to come from families where two caretakers are present (69% versus 56%) and where the caretakers are 16 to 20 years of age (21% versus 9%).[6]

Although only an estimate, the magnitude of this increase is striking enough to warrant serious attention. In some instance this increase may reflect a more accurate reporting system as was the case with Louisiana between 1984 and 1985. However the size and frequency of this increase across several states suggest that the incidence of death due to maltreatment regrettably may be on the rise.

An increase in this statistic is consistent with current trends in infant mortality rates and levels of serious family violence and violent crimes. Although the infant mortality rate declined, on average, 4.5% annually in the 1970's, the annual rate of decline noted in the early 1980's dropped to 2.6%. In 1983, the postneonatal mortality rate, (i.e. death occurring between the ages of 28 days and one year) among black infants actually increased while the rates for white infants remained unchanged.[7] While the Second National Family Violence Survey conducted by Gelles and Straus in 1985 found an overall decrease in levels of violence toward children, the two most severe categories in their index, "threatened with a gun or knife" or "used a gun or knife" increased, although not significantly.[8] This finding, coupled with the increase in child deaths due to maltreatment noted by 14 of the 24 respondents surveyed, suggest that a notable number of children continue to face serious risk of fatal harm.

Perhaps most disturbing from a policy perspective is that for many of these children death occurred after they had been reported on at least one occasion to local child protective service agencies. While there are currently no national statistics with respect to the specific number of children experiencing this pattern, studies undertaken in individual counties or states suggest that the percentage of these deaths previously known to local child welfare agencies range from 25 to 50%.[9]

A variety of reasons may account for the apparent failure on the part of child welfare agencies to protect these children. Even when agencies follow best practice, the unpredictability of human behaviors makes some deaths unavoidable. Further, child protective service agencies are only one component of a broader community service system, including other public agencies, private social service providers, and informal support networks, which share responsibility for protecting children and improving the environment in which they live.

There is no doubt, however, that protective service workers, particularly those responsible for the initial investigation of maltreatment reports, face overwhelming work demands. Over the past ten years, child abuse reports have increased 184%. All of these reports, some two million last year, required at least an initial investigation and half of them were opened for formal protective services. While all state agencies are required by law to investigate reports of abuse and neglect generally within 24 to 48 hours, approximately one-third of the administrators responding to a recent survey by the Child Welfare League of America indicated that they were often unable to meet these standards.[10] Often the sheer volume of reports delay these investigations. In

California,, for example, workers in the emergency response units carry average caseloads of 32.8 families as opposed to the state recommended caseload of 15.8.[11] The changing composition of these reports also accounts for some of the delay. Charges of sexual abuse, which have been increasing and now represent over 14% of all reports, require a higher than average degree of community involvement and coordination both to substantiate as well as to provide effective services.[12]

In response to the growing number of child abuse reports and deaths, several states have initiated comprehensive reviews of their child welfare response and intervention systems. States currently undergoing this review process include Maryland, Mississippi, Louisiana, Pennsylvania and Washington. Also state administrators in Florida and Utah indicated that efforts are underway to develop a more structured risk assessment measure to facilitate the identification of the most "at risk" cases. Another common reform being suggested is developing a mechanism whereby services could be directed to families where abuse could not be substantiated but where the likelihood for maltreatment appeared quite high.

While such reforms may improve the ability of child protective service agencies to direct services to those families most in need or where children remain at risk of future maltreatment, implementing such changes will be limited to the extent budgets can be adjusted to accommodate them. Approximately half of the state administrators interviewed indicated that local resources for child welfare services expanded slightly in 1986 while the remaining half indicated that they were operating with stable or declining budgets. The hardest hit area of the country was the southwest where declining oil profits have drastically reduced state revenues.

Among the impacts of these budget reductions cited by those interviewed were larger caseloads, longer delays in responding to child abuse reports, more cursory investigations of these reports, and a reduction in the range and frequency of services provided maltreated children and their families.

Overall, approximately 43% of all child abuse reports were substantiated in 1985, a figure consistent with a 42% confirmation rate in 1984 identified by American Humane.[13] As summarized in Table 3, wide variation in this rate existed across the forty states responding to this question, ranging from a low of 17% in Virginia to a high of 60% in Nebraska and Maryland. Virtually all of the state administrators surveyed indicated that substantial variation from their state-wide average exists among individual counties, noting that many small, rural areas maintain substantiation rates of as high as 80% while some of the larger urban counties have rates as low as 14%. Although all states have specific criteria for determining if abuse or neglect is present, over half those interviewed said that the personal judgement of those conducting the investigation frequently overrides any specific policy.

The majority of state administrators surveyed said that the pattern of substantiation has not dramatically changed over

TABLE 3

1985 SUBSTANTIATION RATES

STATE	SUBSTANTIATION RATE
ARKANSAS	37
CONNECTICUT	56
DELAWARE	55
FLORIDA	53
HAWAII	55
IDAHO	47
ILLINOIS	47
INDIANA	32
IOWA	30
KANSAS	38
KENTUCKY	44
LOUISIANA	42
MAINE	51
MARYLAND	60
MASSACHUSETTS	51
MICHIGAN	39
MINNESOTA	39
MONTANA	49
NEBRASKA	61
NEVADA	51
NEW HAMPSHIRE	45
NEW JERSEY	38
NEW MEXICO	39
NEW YORK	37
NORTH CAROLINA	36
NORTH DAKOTA	47
OHIO	24
OKLAHOMA	35
OREGON	52
PENNSYLVANIA	37
PUERTO RICO	48
SOUTH CAROLINA	30
SOUTH DAKOTA	44
TEXAS	56
UTAH	33
VERMONT	52
VIRGINIA	17
WEST VIRGINIA	38
WISCONSIN	33
WYOMING	42
AVERAGE	43

the past few years, adding that charges of child neglect remain the most difficult to confirm. Cases of serious physical abuse and sexual abuse are the most likely types of abuse to be substantiated and reports filed by physicians and other mandated reporters are more likely than anonymous reports to result in substantiation.

Most all respondents urged extreme caution in the interpretation of this statistic. The substantiation rate does not always equal the percentage of reports which received CPS services. Frequently a family reported for suspected maltreatment may not present a convincing enough case to be legally defined as involved in abuse or neglect but do present a set of disorders serious enough to warrant social services. Such families may be accepted on to CPS caseloads as "high risk" families or may be referred to local community agencies for support or therapeutic services. Further, cases may be classified as unsubstantiated as a means of securing the family's cooperation in voluntarily entering a treatment program, or to avoid the complex and often destructive aspects of adjudicating a case.

The prevention of child abuse is definitely a higher priority today than five years ago, according to those surveyed. While 21 of the states surveyed said that the child abuse prevention was a higher priority than the treatment of child abuse, nine states reported that prevention was lower. For another 17 states the focus on prevention is increasing but expanding treatment services remains the top consideration.

Within the realm of prevention, over half the states surveyed reported that their most significant prevention activities result from the efforts of the State Children's Trust Fund and/or the State Chapter of NCPCA. Community and county based programs are also prevalent, providing public awareness and education. Presently, the majority of the states are concentrating on education for young and at-risk parents as well as child sex abuse prevention education. While only 11 states have passed legislation which specifically encourages sex abuse prevention education, the majority of states reported a growing number of programs emerging at the community level. Those states with specific policies in this area include Alabama, Alaska, California, Colorado, Idaho, Illinois, Maryland, Ohio, Oregon, Tennessee and Wisconsin. With the introduction of several influential governor's task forces as well as the initiation of statewide multidisciplinary councils, a trend is emerging toward more coordinated prevention efforts.

NOTES

1. These surveys provide timely, although not precise, information regarding reports of abuse and neglect across the nation. Detailed analyses of official state reporting data are conducted by the American Association for Protecting Children, a division of American Humane, who typically release their findings nine months after the close of each year.

2. "Reports of Child Abuse and Neglect Continue to Increase in 1985," Press release, The American Association for Protecting Children, October 29, 1986.

3. The 34 states providing data with respect to the number of child deaths due to maltreatment represent 62% of all children in the Unites States under the age of 18. Assuming that the proportion of deaths due to maltreatment with respect to a state's child population remain constant across all states, we estimate that as many as 1,153 children died from maltreatment in 1986.

4. An exact national number with respect to child deaths due to maltreatment is difficult to determine due to definitional and reporting differences across states. In addition, state-level data on this particular statistic is not routinely maintained in nine states and the District of Columbia. The states not maintaining this figure include Alabama, Florida, Georgia, Michigan, New Hampshire, Tennessee, Texas, Washington and West Virginia.

5. Durfee, Michael. Data and Information Sharing System Report to the Policy Committee. (Los Angeles: Interagency

Council of Child Abuse and Neglect) 1986; Martinez, Louis. Illinois Child Fatalities: A Three Year Statistical Profile. (Springfield: Illinois Department of Children and Family Services, Office of Quality Control and Reporting, Division of Child Protective) 1986.

6. Martinez, 1986.

7. Newberger, C.M., Melnicoe, L.H., and Newberger, E.H. "The American Family in Crisis: Implications for Children." Current Problems in Pediatrics 16 (December, 1986).

8. Strauss, M. and Gelles, R. "Societal Change and Change in Family Violence From 1975 to 1985 As Revealed in Two National Surveys." Journal of Marriage and the Family 48 (August 1986) 465-479.

9. Martinez, 1986; Lambert, Bruce. "Amid Tragedy, Concern For the City's Most Helpless." The New York Times. Sunday, February 1, 1987.

10. Too Young to Run: The Status of Child Abuse in America. (New York: The Child Welfare League of America) 1986.

11. Child Welfare Services: A Review of the Effects of the 1986 Reforms on Abuse and Neglected Children and Their Families. Report prepared by the Legislative Analyst to the State of California General Assembly. May, 1985.

12. American Association for Protecting Children. Highlights of Official Child Neglect and Abuse Reporting, 1984. (Denver, CO: American Humane Association), 1986.

13. American Association for Protecting Children, 1986.

APPENDIX A

Child Abuse and Neglect Reporting Rates
Annual Percent Change, 1981-1986

	1981-82	1982-83	1983-84	1984-85	1985-86
Alabama	%	%	21%	10%	%
Alaska				5	20
Arizona	47	11	29	23	12
Arkansas	2	15	20	Trace	8
California			7	18	20
Colorado		9	10	-8	
Connecticut		18	11	1	
Delaware	6	16		-17	10
D.C.				-1	21
Florida	4	24	27	15	9
Georgia	10	16	10	17	17
Hawaii			10	-3	1
Idaho		2	14	7	2
Illinois	13	10	9	4	1
Indiana		17	12	21	-1
Iowa	1	1		1	8
Kansas		4	9	9	-9
Kentucky	7	10	65	6	6
Louisiana		4	7	36	-6
Maine		19	16	8	5
Maryland			17		
Massachusetts			19	6	5
Michigan		7	5	8	
Minnesota		15		-6	-23
Mississippi				64	13
Missouri	7	1	18	5	1
Montana	11		10	7	
Nebraska		10	41	30	-2
Nevada	13		15	8	11
New Hampshire			20	-5	
New Jersey		19		20	
New Mexico	29	32	6	26	
New York	10	4	9	4	14
North Carolina		4	6	5	
North Dakota	15	10	24	5	6
Ohio		25	40	35	6
Oklahoma	25	14	21	12	9
Oregon	25	17	48	10	7
Pennsylvania			7	4	10
Rhode Island	7	110	190		-13
South Carolina				9	0
South Dakota	9	12	17	39	9
Tennessee			18		
Texas	11	9	8	4	
Utah		32	1	17	3
Vermont		71	15	20	
Virginia	7	2	6	4	
Washington		17	5	-5	9
West Virginia	1	18			
Wisconsin.		11	45	46	10
Wyoming		35	18	-1	
Average Increase	12%	18%	21%	11%	6%
Number of states	21	37	43	47	35

NCPCA FACT SHEET

National Committee for Prevention of Child Abuse
332 S. Michigan Ave., Suite 950, Chicago, IL 60604, (312) 663-3520

No. 9 **Date** April, 1987

NCPCA FACT SHEET
CHILD DEATHS DUE TO MALTREATMENT

How many children die each year as a result of maltreatment?

Variation in the reporting practices and investigatory procedures across the fifty states and the District of Columbia make it difficult to determine the exact scope of the problem. However, official statistics indicate that a minimum of 1,000 children are killed every year as a result of physical abuse or neglect.[1] In 1986, at least 1,200 fatalities were reported.[2] At least one study, which reviewed official death certificates and clinical records, suggests that the actual number may be as high as 5,000.[3]

Which children are most likely to die as a result of maltreatment?

Children reported as child abuse fatalities are much younger, on average, than those children reported for maltreatment--2.6 versus 7.2 years of age.[4] Recent surveys of suspected child abuse deaths in Los Angeles County and the State of Illinois, for example, have found that almost 75% of the victims were one year or younger. Comparisons of reported child abuse fatalities tc those children reported for maltreatment suggest that children who die as a result of abuse or neglect are more likely to come from families where two caretakers are present (69% compared to 56%) and where the caretakers are 16 to 20 years of age (21% compared to 9%). Evidence also exists that minority children living in low income households are overrepresented in the fatality statistics.[5]

Is the number increasing?

A national survey conducted by the National Committee for Prevention of Child Abuse in the fall of 1986 suggests that child abuse fatalities are on the rise. Between 1985 and 1986, reported deaths due to maltreatment rose an average of 23% in the 34 states able to provide NCPCA with this information.

Could this increase be a result of better identification of deaths due to maltreatment?

In some instances, this increase may reflect a more accurate identification system. However, the size and frequency of this increase in several states suggest that the incidence of death due to maltreatment regrettably is on the rise. An increase in this statistic is consistent with current trends noted in infant mortality rates and in levels of serious family violence and violent crimes.[6,7,8]

What are the most common immediate causes for these deaths?

According to data from the American Humane Association, approximately half of the children die as a result of battering. In some instances, death is the cumulative result of repeated beatings while in other cases death results from a single violent episode. The other half of the victims die as a result of child neglect in which the parents failed to provide for a child's basic needs such as failure to secure needed medical care or adequate supervision.[9]

What percentage of these children are reported to local child protective service agencies prior to their death?

While there are currently no national statistics with respect to this question, studies undertaken in individual counties or states, suggest that the percentage of those cases previously known to local child welfare agencies range from 25 to 50%.[10]

Can't public agencies better protect those children whose cases are known to them?

Even when agencies follow best practice, the unpredictability of human behaviors makes some deaths unavoidable. Further, child protective service agencies are only one component of a broader community service system, including other public agencies, private social service providers, and informal support networks, which share responsibility for protecting children and improving the environment in which they live.

(over)

There is no doubt, however, that protective service workers, particularly those responsible for the initial investigation of maltreatment reports, face overwhelming work demands. Over the past ten years, child abuse reports have increased 184%. Over 1.9 million reports were filed in 1986, all of which required an initial investigation and half of which were opened for protective services.[11] While all state agencies are required by law to investigate reports of abuse and neglect usually within 24 or 48 hours, approximately one-third of the administrators responding to a recent survey indicated that they were often unable to meet these requirements due to the volume of reports.[12]

What can be done to prevent child abuse deaths?

Most importantly, prevention efforts need to be expanded to provide families, particularly young single mothers with infants, the support they need to care for and protect their children. Responsibility for creating such a continuum of prevention services needs to be shared by all public and private agencies serving children and their families. With respect to improving the child welfare system, several states have developed statewide task forces to pinpoint specific problems in the current child abuse reporting, investigatory and service systems and to recommend reforms. At the national level, both the American Humane Association and the National Association of Public Child Welfare Administrators, a division of the American Public Welfare Association, and the Child Welfare League of America are developing model child welfare practices and policy standards. Others, such as the National Association of Social Workers and the Children's Defense Fund, are advocating to reform the conditions under which social workers operate and for an increase in state and federal resources for child welfare services.

NOTES

1. American Association for Protecting Children. *Highlights of Official Child Neglect and Abuse Reporting, 1984*. (Denver, Co: American Human Association), 1986.
2. Daro, D. and Mitchel, L. *Deaths Due to Maltreatment Soar*. (Chicago, IL: National Committee for Prevention of Child Abuse). 1987.
3. Christoffel, K. K., et al, "Epidemiology of Fatal Child Abuse: International Mortality Data," *Journal of Chronic Disease*. 34. (1981)
4. American Association for Protecting Children, 1986.
5. Durfee, Michael. *Data and Information Sharing System Report to the Policy Committee*. (Los Angeles: Interagency Council of Child Abuse and Neglect) 1986; Martinez, Louis. *Illinois Child Fatalities: A Three Year Statistical Profile*. (Springfield: Illinois Department of Children and Family Services, Office of Quality Control and Reporting, Division of Child Protective Services) 1986.
6. Newberger, C.M., Melnicoe, L.H., and Newberger, E.H. "The American Family in Crisis: Implications for Children." *Current Problems in Pediatrics* 16 (December, 1986).
7. Strauss, M. and Gelles, R. "Societal Change and Change in Family Violence From 1975 to 1985 As Revealed in Two National Surveys." *Journal of Marriage and the Family* 48 (August 1986) 465-479.
8. "Urban Murders: On The Rise" *Newsweek* (February 9, 1987) 30.
9. American Association for Protecting Children, 1986.
10. Martinez, 1986; Lambert, Bruce. "Amid Tragedy, Concern For the City's Most Helpless." *The New York Times*. Sunday, February 1, 1987.
11. American Association for Protecting Children, 1986.
12. *Too Young to Run: The Status of Child Abuse in America*. (New York: The Child Welfare League of America) 1986.

Senator Dodd. That is excellent testimony, very constructive suggestions. And I know the people from the National Center are here as well, and will take your suggestions in the spirit in which they are offered. We will hear from them later, so that maybe they can address some of the questions you have raised about the ability of staff to get around and other concerns. They face problems as well. I am not part of the Administration, as you know, but I know they are under constraints—we are all under fiscal constraints—and it is difficult in many instances to get around.

Before turning to our next witness who, coincidentally, happens to come from the State of the gentleman here to my left—rarely is he to my left, I want you to know—[Laughter.]

Senator Thurmond. What a true statement.

Senator Dodd. Yes. But I am delighted—he always comes to our hearings at the Subcommittee level, and I feel fortunate indeed to have him as my Ranking Minority Member on this Subcommittee. He is the former President Pro Tempore of the Senate, and a fine friend, and a wonderful Senator—Strom Thurmond.

Strom, do you have any comments you would like to make? I know you are very busy.

OPENING STATEMENT OF SENATOR THURMOND

Senator Thurmond. Thank you very much, Mr. Chairman.

I want to congratulate you on holding this hearing.

Senator Dodd. Thank you, sir.

Senator Thurmond. I am in another committee, and I have got to get back, but I wanted the pleasure of introducing your next witness here.

Mr. Chairman, the growth in reported incidents of child abuse, as well as research suggesting that such abuse may have long-term negative results for both the child and society, have increased concerns regarding how such incidents can be prevented, and how treatment can be provided for affected children.

Accordingly, I commend you, Mr. Chairman, for moving ahead in the reauthorization of the Child Abuse Prevention and Treatment Act. While we have disagreed on some measures in this Subcommittee, I am confident we can work together on this legislation in reaching a sound reauthorization measure.

Mr. Chairman, I also would like to welcome one of our witnesses today, who is from South Carolina—Ms. Shirley Fitz-Ritson. Ms. Fitz-Ritson currently serves as the Director of the Child Protective and Preventive Service within the South Carolina Department of Social Services. She has extensive experience in this field, having been involved in child protection activities for about 12 years. Ms. Fitz-Ritson has also conducted numerous workshops and research projects involving prevention of child abuse.

I understand she will testify next, and I am very pleased to be here to introduce her and tell you what a fine person she is and how well-qualified she is. I am sure her testimony will make a great contribution to this hearing.

Ms. Fitz-Ritson, we are glad to have you in Washington today, and I am confident the other Members of the Committee will benefit from your valuable insights in this area.

I regret that I have got to go back to another committee, where there are nominations up which are very timely, and I have to be there, but I will take pleasure in reading your testimony.

Again, Mr. Chairman, I want to thank you for your courtesy. It is a pleasure to work with you.

Senator **Dodd**. Thank you.

Senator **Thurmond**. And I wish you well, Ms. Fitz-Ritson.

Ms. **Fitz-Ritson**. Thank you, Senator Thurmond.

[The prepared statement of Senator Thurmond follows:]

STATEMENT BY SENATOR STROM THURMOND (R.-S.C.) BEFORE THE SENATE SUBCOMMITTEE ON CHILDREN REFERENCE "REAUTHORIZATION OF CHILD ABUSE PREVENTION AND TREATMENT ACT" WEDNESDAY, APRIL 1, 2:00 P.M., SD-562.

MR. CHAIRMAN:

The growth in reported incidents of child abuse, as well as research suggesting that such abuse may have long-term negative results for both the child and society, have increased concerns regarding how such incidents can be prevented, and how treatment can be be provided for affected children.

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Ms. Fitz-Ritson, we are glad to have you here today, and I am confident the other members of the Committee will benefit from your valuable insights in this area.

Mr. Chairman , while my schedule may not allow me to stay for the entire hearing, I look forward to reviewing the testimony presented by the witnesses today.

Senator DODD. Well, with that send-off, we are delighted to hear you this afternoon. Is it Fitz-Ritson?

Ms. FITZ-RITSON. Yes.

Senator DODD. That is a good Irish name.

Ms. FITZ-RITSON. Yes. My husband is from Jamaica. What can I say?

Senator Dodd, thank you for the opportunity to testify before you as a family and child advocate and as an administrator in a public agency mandated to assess and treat child abuse and neglect.

During 1985, utilizing funds from the National Center on Child Abuse and Neglect, the South Carolina Department of Social Services conducted a study of child fatalities resulting from abuse and neglect. Commissioner James L. Solomon empaneled a 21-member multidisciplinary committee to review the deaths of 37 children. These deaths had occurred between 1983 and 1985.

One of the major findings of the Committee focused on the lack of adequate resources to prevent, assess and treat families with child abuse and neglect problems.

Related to this finding was the fact that the caseload size of the workers involved in the cases studied ranged from 30 to 60 cases. Excessively high caseloads negatively affect caseworker ability to protect children.

South Carolina has approximately 400 child protective services workers who investigated 17,544 reports of abuse and neglect involving 43,860 children in 1985. South Carolina, like all States, has experienced a consistent increase in the number of cases investigated.

In 1975, the Department investigated 1,927 reports as compared to the 9,293 reports in 1983, and of course, the 17,000 reports that I have just mentioned. We are anticipating that over 21,000 reports will be investigated in 1986.

The resources made available by the Federal Government through the National Center on Child Abuse and Neglect are essential and must be maintained to assist us in treating families who have abuse and neglect problems.

In South Carolina, we have used the National Center funds in a number of ways, primarily to implement new programs designed to protect children and to rehabilitate families. South Carolina has specifically used these funds to enhance the skills of front-line practitioners from the fields of law enforcement, mental health and child protective services, directly related to the assessment and treatment of sexual abuse cases. We have also used these funds to enhance services in rural communities. We have established, for example, a family reunification project in Marlboro County.

The National Center funding must continue because of the ever-increasing number of reports that come into our agency. It also must be continued because we also see that child fatalities are on the rise.

As Anne has already indicated to you in her testimony, the survey conducted by the National Committee showed a 23 percent increase in the number of fatalities between 1985 and 1986.

One of the questions I am frequently asked about child deaths is why do these deaths occur. There is no simple answer. However, I would like to mention to you what I believe to be some contributing factors.

First, the inability of parents to cope with the stresses of parenting, and the demands that our society places on the individual to be self-sufficient. The absence of support systems which enable parents to have the resources required to meet their own physical and emotional needs, as well as the physical and emotional needs of their children, is a second factor.

A third factor is the absence of preventive services to families who are in trouble, but who have not abused and neglected their children, who are reported to our agency simply because the resources did not exist to allow us to provide preventive services so that families have access to the agency and can receive assistance.

A fourth thing I would like to mention to you is the dwindling of resources available to families with abuse and neglect problems. I must be honest with you today and say that if States are provided with all of the resources they request, some deaths will continue to occur, specifically, those deaths that are the result of psychotic breaks that parents experience, and deaths where a parent temporarily loses complete control. While we cannot save all of the children, we must do all that we can to protect our most valuable resource, the children of our society and families.

Senator DODD. Thank you very much for your testimony.

[The prepared statement of Ms. Fitz-Ritson follows:]

Testimony Before The Senate Subcommittee on Children, Families, Drugs and Alcoholism

During the third quarter of calendar year 1985, there was a significant increase in the number of child fatalities related to parental abuse and neglect in South Carolina. The twenty-one (21) fatalities in 1985 represented a hundred and ten percent (110%) increase over the ten (10) deaths in 1983 and a two hundred and fifty percent (250%) increase over the six (6) deaths in 1984.

Recognizing that fatalities from abuse and neglect are an interagency and community responsibility, the Commissioner of the South Carolina Department of Social Services (DSS), Mr. James L. Solomon, with the approval of the South Carolina Board of Social Services, appointed a twenty-one member, independent, multidisciplinary committee, to study this emotionally laden, complex social problem.

Cases included in the review were those cases where:

1. The death was reported to the South Carolina DSS during calendar year 1983, 1984, or 1985, and
2. Either the Department of Social Services or law enforcement had determined that the death was a result of abuse or neglect by a caretaker.

The overall finding of the Committee was that South Carolina's Child Welfare System (which includes: The Family Court; The Solicitor's Office; The Department of Social Services;

Coroners; Law Enforcement; Hospital; Department of Health and Environmental Control; Department of Mental Health; The Medical Community and Magistrates Court) was inadequate to protect fifty percent (50%) of the Children including in the Study. The inadequacies identified:

1. The absence of child abuse and neglect curriculum in the professional training programs for social work, medicine, law, and the allied health professions;
2. The absence of essential resources to assess and treat child maltreatment. This was clearly represented by the shortage of staff and the excessive caseloads carried by CPS assessment workers. The caseload size of the workers involved in the study ranged from thirty (30) to sixty (60) cases. In 1985, South Carolina's four hundred (400) CPS workers investigated seventeen thousand five hundred and forty-four (17,544) reports involving forty-three thousand eight hundred and sixty (43,860) children.

The South Carolina Child Fatalities Oversight Committee was established by DSS and charged with the responsibility for ensuring that the recommendations in the Child Fatalities Report are addressed.

The Oversight Committee has drafted its interim report. The report outlines the changes which have occurred as the result of the implementation of many of the initial recommendations. The reports goes on to state that the projected revenue short-falls faced by the State will directly impact the implementation of the recommendations. If the needs of abusive families are not met, the victimization of children will continue to increase on an annual basis. The consistent increase of reports in South Carolina is evidenced by the 1,927 reports investigated in 1975 in comparison to the 9,293 reports in 1980 and the 17,544 reports in 1985.

The lack of resources is a recurrent theme across this country. Without the resources provided by the Federal Government through the National Center on Child Abuse and Neglect, I shudder to think what would happen in South Carolina and the nation.

These funds have been used in South Carolina to:

1. Provide specialized training in the identification and treatment of physical abuse, sexual abuse and neglect to private practitioners, law enforcement officers, and mental health and CPS professionals; and
2. Establish new and innovative programs such as the South Carolina Sexual Abuse Self Referral Project which is being piloted in six (6) counties.

The funding has been used to put in place services in rural communities which lack sufficient resources to meet the needs of abused and neglected children. One such program is the Family Reunification Project in Marlboro County.

Although these initiatives are representatives of resource enhancement for children who are victims of child abuse and neglect, it is clearly evident that fundings must continue to be made available as the number of children who die as a result of abuse and neglect continues to increase. South Carolina participated in a recent survey conducted by the National Committee for the Prevention of Child Abuse which reported that child deaths due to maltreatment increased by twenty-three percent (23%) between 1985 and 1986.

One of the questions I am frequently asked about child deaths is "Why do these deaths occur?" There is no simple answer; however, some contributing factors are:

1. The inability of parents to cope with the stresses of parenting;
2. The absence of support systems which enable parents to have the resources required to meet their physical and emotional needs as well as the physical and emotional needs of their children;
3. The absence of Preventive Services to families who are in trouble but have not abused their children; and
4. The dwindling of resources available to families with abuse and neglect problems.

I must be honest with you today and say that if states are provided with all of the resources they request, some deaths would still not be prevented. Specifically, those deaths that are the result of psychotic breaks and death where a parent temporarily looses complete control. While we cannot save all the children, we must do all we can to protect our most valuable resource.

Respectfully Submitted,

Shirley Fitz-Ritson, Director
Child Protective and Preventive
Services
S. C. Department of Social Services

Senator DODD. Larry Aber, we are glad to hear from you.

Dr. ABER. Mr. Chairman, thank you very much.

It is my pleasure to provide testimony on behalf of the American Psychological Association in this hearing today on the reauthorization of the Child Abuse Prevention and Treatment Act.

I am going to take your advice seriously and summarize my comments and give you the full written version for the record.

I am Larry Aber, and I work at Columbia University as an Assistant Professor of Clinical and Developmental Psychology, and as you noted in your introductory comments, I have worked on the policy, research and service sides of this fence. So it comes as a bit of a surprise to me that I am here today talking primarily about research, even though the other two areas are enormously important, because your Committee faces such a large number of important and complex issues as it considers the reauthorization of the Child Abuse Prevention and Treatment Act.

I am going to talk about just one important issue, the issue of the relationship between science policy and service policy in this area, because I think it holds one key to helping improve things.

Last year, before another subcommittee, I pointed out how important continued progress on the support of good research is in this area, and I want to give you two examples of the ways I think good research can help us improve our prevention and treatment efforts.

We have heard from a number of other speakers today that the risk of a maltreated child growing up to maltreat his or her own children is much greater than the risk for a child growing up in the general population. We refer to this increased risk as the intergenerational transmission of child abuse—abused children become abusive parents.

And our best data indicates that this is true—about 3 percent of the parents in the general population are reported as maltreating their children, and about 30 percent——

Senator DODD. Could you hold for just one moment, Dr. Aber? The Majority Leader is calling. We will just take a five-minute recess.

[Recess.]

Senator DODD. The Subcommittee will resume.

We are going to have a vote, I will say, fairly shortly on the Highway Bill. So we will just proceed as fast as we can and try and cover as much ground as we can. I do apologize to all of you.

Proceed, Dr. Aber.

Dr. ABER. I was commenting on the relationship between science policy and service policy and describing what I thought was the need for better basic research in this area. And I wanted to give two examples of what I was talking about.

The first has to do with what we know and do not know about the inter-generational transmission of abuse and neglect. As I mentioned, about 3 percent of the general population of parents abuse and neglect their children, and as many as 30 percent of children who themselves were abused and neglected later grow up to abuse and neglect their children. That is the best scientific evidence we have right now.

That represents a tenfold increase in our ability to predict abuse and neglect, and it is a risk factor in that way. But we also have the opportunity to learn from the 70 percent of abused and neglected children who do not grow up to abuse and neglect their own children. In other words, we have not yet been able to specify the causal processes by which some maltreated go on to abuse and neglect their own children while others do not.

A second example. Recent studies have been able to document some of the negative effects of maltreatment on young children's social, emotional and cognitive development. For instance, we have compared maltreated to non-maltreated children who are similar in other ways and found maltreated infants to be more insecure with their parents, maltreated preschool children to be more dependent and less curious, and maltreated school-age children to be more depressed, socially withdrawn and aggressive. These are the kinds of problems that in turn we know lead to problems like school failure and early peer problems, like peer rejection, which in turn we know lead to later problems in adolescence, like dropping out of school and delinquency.

However, not all maltreated children become more insecure, more dependent, more cognitively immature, more depressed. In both of these examples, the children who break prediction hold an important key to understanding how to prevent child maltreatment and to prevent the developmental impairments caused by child maltreatment. However, to use this key to learn more about how to prevent child maltreatment requires much better research than we are presently typically conducting, using powerful longitudinal designs and methods.

It is now an accepted fact in our area of science that if we want to learn about these causal processes, about why some people at risk do develop problems while other people at risk do not, we have to use longitudinal designs. And it is especially important to study children during periods that we call "developmental transitions"—the transition from infancy to toddlerhood, the transition from preschool to the early school-age years, when children's development is especially open to being influenced and to change.

In summary, then, preventing child maltreatment and its negative consequences requires better scientific knowledge of the causal processes that lead to maltreatment and lead to impairments in maltreatment.

In turn, better knowledge of causal processes requires rigorous scientific research using longitudinal designs, ideally over periods of developmental transition. As I indicated in earlier testimony, I do not believe the Federal Government, especially NCCAN, has provided the direction and leadership necessary to engage our best scientific minds to address this pressing area of research.

For instance, it has been unfortunately lax recently in employing scientific rather than political criteria in evaluating research proposals. Consequently, its funded studies sometimes use scientifically inferior designs and methods. I hope and believe that the attention that has been paid to this is beginning to increase our understanding of the need for better research, better methods for research, but we still have a long way to go.

As the continued increase in abuse reports and in foster care placements due to maltreatment attest, we still construct programs and policies to prevent maltreatment based on an inadequate scientific knowledge base. Indeed, if we approached research on polio the way we approach research on child abuse and neglect, we would still have a lot of children in iron lungs.

If, then, you accept, as I do, the need for a better scientific knowledge base, then science policy should be directed at making the development of such a knowledge base more probable. Several concrete steps can be taken to improve scientific policy in the area of child protection under the Reauthorization Act.

First, longitudinal research takes time to implement and conduct. Also, rigorous research with high-risk samples of children and youth are much more difficult to complete than research with low-risk samples. Consequently, the American Psychological Association recommends that the reauthorization of the Child Abuse Prevention and Treatment Act amend the grant years' limit from three to five years. This simple change will serve to encourage scientists to design more powerful types of studies, the longitudinal type. The present three-year limit almost virtually prevents the design of effective longitudinal studies.

Second, the National Center and ACYF could improve its understanding of and relationship with the scientific research community. Grant review practices that do not reward scientific merit have had a chilling effect on the quality of scientific research in the area. Rather than discourage scientific studies, NCCAN and the Federal Government should be encouraging them, not just in the present, but by planning for the future, as other people have mentioned.

Third, similarly, the National Center should be exploring ways to create incentives for closer collaborations between research scientists, treatment and prevention programs, and policymakers. The culture of research and service operates on very different priorities, and if we are going to make progress in this area, we have to increase cooperation between service providers and policymakers on the one hand and scientists on the other.

Finally, longitudinal research with high-risk children cannot be conducted on-the-cheap. The present levels of funding of rigorous scientific research should be reviewed and compared to the potential cost savings derived from prevention efforts founded on a better understanding of causal processes.

I am not saying that research should be the Federal Government's highest priority in the child protection field. What I am saying is the value of the research should be compared against its potential benefit and ability to help save money.

We are spending money at levels which, in my opinion, help salve our consciences, but do not help reach our real goal of prevention. Let us get practical and fund what we must to learn what we need to help prevent child maltreatment.

In this respect the American Psychological Association recommends that the funding authorization of the Child Abuse Prevention and Treatment Act be increased to $50 million in fiscal year 1988 from the fiscal year 1987 authorization of $43.1 million.

Thank you for the opportunity to present testimony. I would be happy to provide any further information you wish for the record.

Senator Dodd. Thank you very much, Dr. Aber.

[The prepared statement of Dr. Aber follows:]

American
Psychological
Association

TESTIMONY OF

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On Behalf of

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

before the

UNITED STATES SENATE

Committee on Labor and Human Resources

Subcommittee on Children, Families, Drugs and Alcoholism

on the subject of

REAUTHORIZATION OF THE CHILD ABUSE PREVENTION AND TREATMENT ACT

April 1, 1987

The Honorable Christopher Dodd, Chair

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Mr. Chairman and members of the Subcommittee on Children, Families, Drugs and Alcoholism, it is my pleasure to provide testimony on behalf of the American Psychological Association for this hearing on the reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA).

My name is J. Lawrence Aber. I am an Assistant Professor of Clinical and Developmental Psychology at Barnard College and the Graduate Faculty of Columbia University, where I am also the Director of the Center for Toddler Development, a service, research and training program for young children and their parents. I conduct research on the development of children and adolescents at-risk (for instance, maltreated children and multiproblem adolescents). My research is designed to contribute both to the basic scientific knowledge base on risk and human development and to help guide program and policy efforts on behalf of children and youth at-risk. Through these activities, I've been a Principal Investigator or Co-Investigator on research grants from Federal agencies (including the National Center on Child Abuse and Neglect and the National Institute of Mental Health) and from private foundations. And it is primarily as a research scientist that I come before you today, representing the American Psychological Association.

Your subcommittee faces a host of important and complex issues as it considers the reauthorization of the Child Abuse Prevention and Treatment Act, P.L. 93-247. In my testimony, I will discuss just one important area of concern and make a few specific recommendations to address this area of concern. The general area is the relationship between science policy and service policy in the field of child abuse and neglect. Last year, before another subcommittee of Congress, I pointed out how important continued progress in research on the causes and consequences of child maltreatment is to the development of effective prevention and treatment programs and to the evaluation of program and policy efforts on behalf of maltreated children. At this point in the history of the child protection field, the most valuable type of research for program and policy efforts is research on the causal processes involved in the etiology and developmental sequelae of child maltreatment. It is very difficult to imagine how we will make progress in preventing child maltreatment without more powerful and precise knowledge of the causes and consequences of child maltreatment.

I will use two examples to illustrate my point that improvements in treatment and prevention efforts require better scientific information about causal processes.

1. The risk of a maltreated child growing up to become a parent who abuses or neglects his/her own children appears to be about 10 times greater than the risk of becoming a maltreating parent in the general population (30% vs. 3%). This is what we mean when we say that a parent's own history of maltreatment constitutes a risk factor for future maltreatment. But we know almost nothing about why the majority of children who are maltreated are able to break the inter-generational cycle of abuse/neglect and grow up to

become good (or at least adequate) parents. In other words, we have not yet been able to specify the causal processes by which some maltreated children go on to abuse/neglect their own children while others do not.

2. Similarly, recent studies have been able to document some of the negative effects of maltreatment on young children's social, emotional and cognitive development. For instance, compared to similar non-maltreated children, maltreated children on average exhibit greater insecurity with their parents during infancy and toddlerhood; more dependency and less curiosity and cognitive maturity in the preschool years; and more depression, social withdrawal and aggression in the early school-age years. These age-specific impairments in the development of maltreated children may be the precursors to later problems, such as school failure, and disturbed peer relationships. In turn, early school failure and peer rejection/isolation are powerful predictors of later problems like school drop-out, delinquency and substance abuse in adolescence.

However, not all maltreated children become more insecure, dependent, cognitively immature, depressed, withdrawn and aggressive. Indeed, some children exhibit remarkable resilience in the face of maltreatment and develop great strengths. Once again, we unfortunately know very little about why some maltreated children break predictions and exhibit great resilience.

In both of these examples, the children who break prediction hold one important key to understanding how to prevent child maltreatment and to prevent the developmental impairments caused by child maltreatment. However, to use this key to learn more about how to prevent child maltreatment requires scientific research, using powerful longitudinal designs and methods. It is now an accepted fact in the sciences of human development that if we want to learn about the causes of such troubling phenomena as child maltreatment, school failure and substance abuse, we must study children-at-risk over extended time periods. It is especially important to study children during periods we call "developmental transitions", periods of rapid growth and reorganization of the child's emotions, thoughts, behaviors, and social relationships. This is because during periods of developmental transitions - for example the transitions from infancy-to-toddlerhood (1 to 3 years), preschool age (4 to 7 years), and pre-adolescence to early adolescence (10 to 15 years) - the children's patterns of feeling, thinking, behaving and relating are, by definition, more fluid than at other periods, and thus more open and receptive to change.

In summary, preventing child maltreatment and its negative consequences requires better knowledge of the causal processes that lead to maltreatment and to the impairments associated with maltreatment. In turn, better knowledge of causal processes requires rigorous scientific research using longitudinal designs, ideally over periods of developmental transition.

As I indicated in earlier testimony, I do not believe that the Federal government, especially the National Center on Child Abuse and Neglect within ACYF, has provided the direction and leadership necessary to engage our best developmental scientists to address this pressing area of research. For instance, it has been lax in employing scientific (rather than political) criteria in the evaluation of research proposals. Consequently, it has funded studies which use scientifically inferior designs (e.g., retrospective studies nather than prospective studies) and methods. I hope and believe that the need for better scientific research on causal processes in child maltreatment to guide program and policy efforts in becoming more widely appreciated. But we still have a very long way to go. As the continued increases in child abuse reports and in foster care placements due to maltreatment attest, we still construct programs and policies to prevent maltreatment based on our inadequate scientific knowledge base.

If, then, you accept as I do the need for a better scientific knowledge base, then science policy should be directed at making the development of such a knowledge base more probable. Several concrete steps can be taken to improve science policy in the area of child protection.

1. Longitudinal research takes time to implement and conduct. Also, rigorous research with high-risk samples of children and youth is

much more difficult to complete than studies with non-risk samples. Consequently, the American Psychological Association recommends that the reauthorization of CAPTA should amend the grant years limit from 3 to 5 years. This simple change will serve to encourage scientists to design the most powerful types of studies: longitudinal studies of causal processes. The present 3 year limit on research grants virtually prevents the design and effective conduct of longitudinal studies.

2. NCCAN and ACYF must improve its understanding of and relationship with the scientific research community. Grant review practices that do not reward scientific merit have a chilling effect on the quality of scientific research on child maltreatment. Rather than discourage the best scientific studies, NCCAN and the Federal government should be encouraging them, not just in the present but by planning for the future. A program of research training in child maltreatment would both help NCCAN learn to support scientific efforts but also help us attract a new generation of research scientists to this effort.

3. Similarly, NCCAN should be exploring ways to create incentives for closer collaboration between research scientists and prevention and treatment programs in the design and conduct of rigorous research. The cultures of research and service operate on very different priorities. Both researchers and service

providers/policymakers need to overcome the obstacle to rigorous scientific research which helps guide program and policy efforts on behalf of maltreated children.

4. Finally, longitudinal research with high-risk children cannot be conducted on the cheap. The present levels of funding for rigorous scientific research should be reviewed and compared to the potential cost savings derived from prevention efforts founded on a better understanding of causal processes. We are spending money at levels which help salve our consciences, but which do not help in reaching our goal of prevention. Let's get practical and fund what we must to learn what we need to help prevent child maltreatment. The American Psychological Association recommends that the funding authorization be increased to $50 million for FY 88 (from the FY 87 authorization of $43.1 million).

Thank you for the opportunity to present this testimony in support of the reauthorization of P.L. 93-247, the Child Abuse Prevention and Treatment Act. If I can be of any further assistance during your deliberations, please feel free to call on me.

Senator **Dodd**. Dr. Whitworth, we welcome you. Please proceed.

Dr. **Whitworth**. Thank you, Senator.

I am here today representing the American Academy of Pediatrics, which is made up of 30,000 pediatricians across the country. The Academy strongly supports the reauthorization of the Child Abuse Prevention and Treatment Act of 1974.

We have some specific recommendations and some comments which are taken from my testimony, which has been submitted to you for review and inclusion in the record.

Last year, we know 2 million cases of child abuse were reported. This figure, I think, is helpful in focusing on the overall magnitude of the problem, but I would hasten to add that we still do not know the true incidence of child abuse and neglect in this country because no reliable study has yet been done to document that true incidence. That will be reflected in some of the recommendations noted in my testimony.

In the five-year period between 1981 and 1986, there has been a dramatic change in public awareness of the problem of child abuse and neglect. Sexual abuse has been rediscovered, reflected by tremendous increases in numbers of reports. All States do now have reporting laws, and there has been a significant increase in our knowledge due to research and evaluation efforts.

New initiatives by the National Center for Child Abuse and Neglect in interdisciplinary training, the development of National Resource Centers, and better coordination among child protective services agencies, mental health, and law enforcement are to be commended.

Through your leadership, Mr. Chairman, and with the help of the National Committee for Prevention, and the Child Abuse Coalition, 38 States have now enacted children's trust funds to focus resources for prevention. And as I mentioned, you and the Committee should be commended.

I am happy to report, at least, based on information that I can provide you for the State of Florida and also for the American Academy of Pediatrics, a number of organizations have also rediscovered child abuse and have focused new attention on the problem. We have noted, for example, that over a period of several years, there has been a remarkably small number of physicians, and especially a remarkably small number of pediatricians reporting child abuse in the State of Florida. As you may know, we started a statewide system of multidisciplinary teams, each of which was headed by a pediatrician across the State, and subsequent to the initiation of that program, there has been at least a twofold increase in the percentage of reports coming from pediatricians and health professionals. And we feel that that is a reflection of the increased involvement of pediatricians on a statewide basis.

It should also be noted that there are currently 130 pediatricians in the State of Florida who are providing direct service to abused and neglected children on a regular basis.

In the same five-year period that we noted before, there have also been some disturbing trends. And as others have testified, the increase in reporting has risen at an alarming rate, without a concomitant or significant increase in commitment to funding on a State level. When we looked at the increase in reports as compared to the increase in State funding in the State of Florida, there was approximately a 30 percent increase in reports at the same time there was approximately a 2 percent increase in State dollars to provide additional services for those reports.

I think it should also be noted that even though there is a considerable amount of discussion and talk about unconfirmed reports, what actually is happening is that most of the "unfounded" or "unconfirmed" reports are simply reports that workers have not been able to generate enough information to make a decision as to whether those reports are founded or unfounded.

False allegations should also be noted to be on the increase, especially surrounding custody issues, and these generate major problems from the standpoint of staff time.

Child deaths, as has been noted by everyone here, is of particular concern to everyone involved, for a variety of different reasons. What I will talk about today and what I will respond to today is primarily my opinion, because I think there are a variety of different things that are simply not known, and to go beyond venturing an opinion would not be based on fact. And this in itself will generate some recommendations.

Some factors that we do know have had an effect on the increase in reports in child deaths as related to abuse and neglect is the fact that for a long period of time, medical examiners were signing out deaths in children without actually doing autopsies or based on, in essence, secondhand information, rather than direct information as to the clinical status of the patient or even sometimes direct observation.

It is known that with an increase in percentage of autopsies and with an increase in the amount of information provided to the medical examiner, the causes of death have shown a significant change in that they tend to reflect actual anatomic findings rather than reflecting simply an opinion.

It is also true that medical examiners have recently discovered child abuse and are much more likely now to make the diagnosis of child abuse or at least a nonaccidental death report than they have been in the past. We do not pretend that this is a complete explanation as to why the statistics have changed or why there has been a significant increase in the number of reported deaths, but it certainly has had some effect.

The major problem, as has been noted before by others, is a total lack of standardization for reporting and collecting data on child deaths, and this is not simply a matter of child death issues, but is a matter of a variety of different kinds of data that relate to child abuse and neglect on a nationwide basis.

Trends cannot be adequately monitored, and an adequate analysis cannot be made if the database is not constant or if the database is not somehow controlled. This is one area where Federal assistance would be extraordinarily helpful to all of us in making some sense out of a variety of different kinds of data which are not necessarily comparable at the present time.

We feel that the National Center for Child Abuse and Neglect, having been founded in 1974, has largely fulfilled the mandates of legislation in spite of inadequate funding and resources.

Several issues continue to demand Congressional support and attention. For example, there is a crying need for a well-done national incidence study, as I mentioned before. The first study was poorly conceived and did not draw on the resources of the National Center for Health Statistics, the Census Bureau, or the National Centers for Disease Control. Instead data was collected which was voluntarily submitted by the States, and the resultant data is not only inaccurate but misleading. We recommend a new study be undertaken with much more careful attention to design.

In other areas of research, we are also concerned about the paucity of control studies done in the area of prevention and the apparent focus on support for research on the social aspects of abuse and neglect, when there has been little support for research in pediatric, psychiatric, or epidemiological aspects of child abuse and neglect.

Our greatest concern, however, is the need for a major study on the natural history of abused children as reflected by how many children become abusive and how many are responsive to treatment and grow up to continue to lead nonabusive lives. Such a study will require a collaboration and multidisciplinary approach by the National Center and by others involved.

Our recommendations therefore include improved coordination between the variety of agencies with which NCCAN should and must deal to develop a muitidisciplinary approach and a total approach to the problem of child abuse and neglect and if this requires an administrative change in the Department so that NCCAN can move up to a higher position in the administrative hierarchy, then that should be a recommendation as well.

We also recommend that the research effort in NCCAN be redesigned as outlined in my previous comments and that there be a commitment for the use of Federal funds to expand services in States where local resources have been inadequate to meet the demands of increased reporting.

Thank you.

Senator Dodd. Thank you very much.

[The prepared statement of Dr. Whitworth, with an attachment, follows:]

American Academy of Pediatrics

TESTIMONY

BEFORE THE

CHILDREN, FAMILY, DRUGS AND ALCOHOLISM
SUBCOMMITTEE

LABOR AND HUMAN RESOURCES
COMMITTEE

OF THE

UNITED STATES SENATE

ON

REAUTHORIZATION OF THE CHILD ABUSE PREVENTION
AND TREATMENT ACT

Presented By:

J. M. Whitworth, M.D., F.A.A.P.

April 1, 1987

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Mr. Chairman, I am J. M. Whitworth, associate professor of pediatrics at the University of Florida, executive medical director of the Florida State Child Protective Services Team System, and a member of the American Academy of Pediatrics Task Force on Child Abuse and Neglect. I am here today on behalf of the Academy, which represents over 30,000 pediatricians dedicated to improving the health and welfare of our nation's infants, children and adolescents.

At the outset I want to commend you, Mr. Chairman, for convening this hearing today. Child maltreatment is clearly one of the most difficult issues facing our children and our society. Despite the public debate and rhetoric about child abuse, it appears too few truly appreciate the ramifications of the abuse and neglect of our children. Child abuse pervades many of our major societal problems. A high proportion of delinquents, substance abusers and suicide victims are the victims of abuse. Moreover, the problem is self perpetuating. Without treatment and attention, abused children are more likely to abuse their offspring, and so the cycle continues. On the positive side, we know much more about how to treat children and how to prevent certain forms of abuse. Tragically, we have just begun to implement what we know, so that abused children still are never identified; others are never treated -- we fear that many die.

The Academy's testimony today will review 1) the nature and scope of the problem of child abuse and neglect; 2) problems and developments in child abuse and neglect within the past five years; 3) the role and effectiveness of the National Center on Child Abuse and Neglect (NCCAN); 4) the import of the "Baby Doe" language; and 5) recommendations for reauthorization.

I. CHILD ABUSE AND NEGLECT: NATURE AND SCOPE OF THE PROBLEM

Child abuse and neglect is not a single entity. It therefore demands a multidisciplinary strategy. The problem includes physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, and medical neglect as well as other entities such as poisoning, sexual exploitation and homicide. Child abuse and neglect is an international problem; it crosses all socio-economic lines. Although physical abuse seems to be more prevalent among those in lower socio-economic strata, sexual and emotional abuse seem to be equally prevalent in all groups.

Last year approximately 2 million cases of child abuse and neglect were reported. This figure does not include the 2,000 - 5,000 deaths which were probably the result of abuse and neglect. Unfortunately, as I will discuss later in my testimony, exact figures on child abuse and neglect are impossible to obtain for we do not have a good reliable incidence study on the problem. Nevertheless, these numbers are a good benchmark as to the scope of the problem and the resulting crisis in terms of unmet needs and demands on child protective service workers.

II. POSITIVE TRENDS 1981-1986

In the past five years we have witnessed a dramatic change in public, private and professional awareness of child abuse and neglect. As the House Select Committee on Children, Youth and Families recently published report concludes, we expect much of this increased attention is due to "rediscovery" of child sexual abuse. I emphasize "rediscovery" since the first report in the medical literature on sexual abuse was in an 1868 paper by a French physician, Ambroise Tardieu, who described his findings after evaluating 616 sexually abused children under age 11 in Paris.

On the positive side, as noted, there clearly is an increased public awareness of the problem of child abuse and neglect. All fifty states have passed reporting laws and protections for families against abuse of their rights and privacy. Many states have provisions for guardians ad litem for children including protective court cases and support for identifiable child protective services at the local level. We have advanced our knowledge about child maltreatment and developed effective programs, approaches and practices. Notably, our research and evaluation efforts have become more sophisticated and confirm that we do know how to prevent and to treat the most prevalent forms of abuse. Federal efforts, particularly during the past two years, have dramatically improved also. While inadequate authorities and fundings continue, the new direction taken by the Children's Bureau and the National Center on Child Abuse and Neglect is excellent. New program initiatives in interdisciplinary training, national resource centers, better coordination between state child protective services (CPS) agencies and mental health and law enforcement systems are commendable. Indeed through your leadership, Senator Dodd, and with the help of the National Committee for the Prevention of Child Abuse, the National Child Abuse Coalition and many state and local groups, 38 states have now enacted children's trust funds to focus additional resources on prevention. We are confident these efforts will begin to yield positive results in the next decade.

Concomitant with the increase in public awareness, there has been a healthy surge in professional awareness. The AAP, AMA, American Psychological Association, American Academy of Child Psychiatry, National Association of Social Workers, Child Welfare League, NAPCWA and many others have formed task forces or committees to plan how to contribute to the solutions to our problems. Further, an increasing number of our students are taking electives and doing their doctoral training in the field of child abuse and neglect. These men and women have grown up in a time when abuse and neglect were regular media fare. Unlike their older mentors, they do not have to redo their basic education and overcome a long history of denial of the existence of the problem.

III. ADVERSE TRENDS 1981-1986

Nevertheless, there is still cause for great concern. Although we have made progress in our knowledge about the causes, consequences and treatment needs of abused children and their families, further progress in actual prevention and treatment has been stalled.

1. Reporting

Overall reports of child abuse and neglect have increased by 55 percent within the last five years; although for the first time last year, the rate of increase in sexual abuse cases declined. The National Center on Child Abuse survey concludes that the 2 million reports of child maltreatment in 1986 represent a 6 percent increase from 1985. This increase is well below the 10 percent increase between 1984 and 1985 as reported by the American Association for Protecting Children, a division of the American Humane Association. The Center cautions that this apparent decline in the rate needs to be interpreted cautiously since these numbers were based on projections for 33 states during the initial six months of the year.

Nevertheless, the overall increase in reports comes at a time when the State Child Protective Service Agencies are struggling to survive against budget reductions and a manpower shortage. Consequently, as the CPS system's ability to keep pace has lagged, the number of "unsubstantiated" reports has increased. Some have wrongly equated "unsubstantiated" with "false". Thus, it has been said that 60-65 percent of all reports to CPS agencies are false, when, in fact, many of these cases are inadequately evaluated because of staff shortages or insufficient time. We should no more label these cases as "false" than we should label them "true". They should be labelled "insufficient information".

As reports have increased, so too have false allegations of abuse, especially in the area of sexual abuse, involving custody disputes. Careful studies have shown that while false allegations exist they are more commonly instigated by adults (6.5 percent of reported cases) than children (1.5 percent of reported cases). It is, in fact, not true to say "children never lie" -- they do, but more commonly they lie when they have been questioned and say they have not been sexually abused, but were (4 percent), than when they say they were sexually abused, and were not (1.5 percent). It is even more common for children never to reveal sexual abuse.

2. Child Treatment Issues

Nor have government agencies mandated to provide services and treat abused children and their families been able to keep pace with the surge in reported cases. The current child protective services system, although required by state law to provide "treatment plans" to families, falls far short of its goals. For example, recent surveys show that mental health services for abused children barely exist in many places. The treatment plans for abusive families consist of a series of 5-10 "parenting classes," a weekly phone call and a monthly visit from a CPS worker. Those families whose children have been molested in day care, school or other institutional settings receive even less help.

Additionally, community mental health and private community centers are full due to the deinstitutionalization of the chronically mentally ill. Our failure to meet the needs of these children and their families will dramatically impact on present as well as future generations. For despite other efforts, the best way to break the cycle of abuse and neglect is to treat its current victims.

3. Child Fatalities

An extremely alarming trend has been the recent increase in child abuse fatalities. The National Committee for the Prevention of Child Abuse found a 29 percent increase in the number of confirmed or suspected deaths due to maltreatment between 1985 and 1986 for the 24 states able to provide such numbers. Between 1984 and 1985 the number of child deaths declined by 2 percent. The Committee found for many of these children, death occurred after the child was reported to local child protective services agencies. In some cases, the children died in protective custody as a result of abuse or neglect by their foster parents or emergency care providers.

It is not clear what has caused this increase. At least 3 possibilities exist:

1) We know there is a relationship between unemployment and serious physical abuse of children. At a 1983 Congressional hearing in Salt Lake City, data was presented from the Child Protection Team in Denver which demonstrated that physical abuse cases rose and fell in parallel with the Colorado unemployment rate over a 14 year period. The data from the past three years extends and confirms the earlier association.

2) The diagnosis of a child abuse fatality requires a careful investigation and an autopsy. In many parts of the United States, children die, they are buried, no one examines the body, and the death certificate is labelled "unexplained", "natural causes" or SIDS (Sudden Infant Death Syndrome). This practice is, happily, decreasing as more cities and counties pull together multidisciplinary child death review committees. The increase in child abuse fatalities may be a component of better recognition. Unfortunately no one tracks these data.

3) The changing demography of the American family has led to more children being left in unsafe settings by teenage or working mothers. Many child abuse deaths are now caused by boyfriends or other caretakers in contrast to the situation 20 years ago.

This lack of certainty in knowing why child abuse fatalities are rising points toward another disturbing problem: the fact that data collection in this field is terrible. Indeed, efforts to monitor trends for research or policy purposes are severely hampered by the continuing lack of reliable data in this field. While our government carefully tracks our labor force, agricultural and industrial production, imports and exports with great care, no one tracks our children.

4. Children with Disabilities

There are 2 issues of great concern regarding abuse and children with disabilities: 1) the degree to which children with disabilities are being abused; and 2) the number of children who have acquired disabilities because of abuse.

Research has acknowledged that disabled children represent a disproportionate number of child abuse victims (Chotiner and Lehr, 1976; Friedrick amd Boreskine, 1976; National Center on Child Abuse and Neglect, 1975; Sandgrund, et al, 1974.) Other isolated studies have indicated a relationship between child abuse, mental retardation, emotional, behavioral and physical disabilities. In a recent study, Diamond and Jaudes (1983) examined the occurrence of child abuse among 86 children with cerebral palsy. Of 18 children with postnatal onset of cerebral palsy, eight resulted from child abuse, five from infection, and three from accidents. Nine other children were abused after the onset of cerebral palsy, and one child was abused after the onset of cerebral palsy which resulted from prior abuse. Thus, in this study, 20% of the children with cerebral palsy were abused. Another 14% were considered at risk for abuse.

Despite these findings, it is difficult to determine accurately the incidence of abuse among disabled children because of the lack of specificity in state reporting requirements. Camblin (1982) found that seven out of 51 state child protection agencies do not have standard reporting forms which would facilitate data collection in child characteristics. Of the 44 states that do have standard reporting forms, 18 do not identify pre-existing handicaps of abused children. Further, Camblin found that in those states requiring this information, 43% of the state agencies regarded the information as inaccurate.

It is important to note, as the PACER group concluded, that children with disabilities are at high risk for child abuse for a number of reasons. These children are generally less able to defend themselves physically. Some children with disabilities may be unaware that they are being abused as they are unable to differentiate between appropriate and inappropriate behavior. Some of these children may be less able to articulate the instance of abuse.

In conclusion, it appears some children with disabilities are at high risk for abuse. Emphasis should be placed on collecting reliable nationwide data on the incidence and needs of disabled children who are abused, as well as training programs for parents and all personnel who deal with these children to prevent and to treat such abuse.

[Material for this section was excerpted from the Council on Exceptional Children briefing paper on Incidence of Child Abuse Among Children With Disabilities.]

IV. THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT (NCCAN)

The National Center on Child Abuse and Neglect was founded in 1974. The original law called for NCCAN to: 1) compile, analyze and publish a summary annually of recently and currently conducted research on child abuse and neglect; 2) develop and maintain an information clearinghouse on all programs, including private programs, showing promise of success for the prevention, identification and treatment of child abuse and neglect; 3) compile and publish training materials for personnel who are engaged or intend to engage in the prevention, identification and treatment of child abuse and neglect; 4) provide technical assistance (directly or through grant or contract) to public and non-profit private agencies and organizations to assist them in planning, improving, developing and carrying out programs and activities relating to the prevention, identification and treatment of child abuse and neglect; 5) conduct research into the causes of child abuse and neglect and into the prevention, identification and treatment thereof; and 6) make a complete and full study and investigation of the national incidence of child abuse and neglect, including a determination of the extent to which incidents of child abuse and neglect are increasing in number or severity.

As you are aware, the Center's responsibilities have been expanded since that time to include an emphasis on sexual abuse, family violence prevention and services, and promotion of children's trust funds. As you are also well aware, funding for this agency has never approached needed levels.

The Academy believes that the Center is extremely important if we are to build a strong federal presence in the field of child abuse and neglect. Indeed there is no question that compared with years prior to 1973, there is more of a federal effort in child abuse and neglect. Although the Academy has been critical of the Center in the past, we are very pleased with the directions currently being pursued by the NCCAN and the Children's Bureau. Nevertheless, there is an urgent need for a stronger, federal effort in the area of child maltreatment. Several of these issues demand Congressional support and attention:

1. National Incidence Study

The first national incidence study mandated by law was poorly conceived. Rather than utilize the expertise of other federal agencies, such as the National Center for Health Statistics, the Census Bureau and the national Centers for Disease Control, the study done under contract to NCCAN used figures voluntarily submitted by the states -- a notoriously poor method of data collection. The study, therefore, has led to the impression that child abuse and neglect is primarily a problem of the poor and tends to understate the severity of the problem. Sexual abuse also has been grossly underreported in this study.

2. Research Efforts

Despite the fact that research on prevention and demonstration programs is one of the NCCAN's primary aims, in a 1983 review article in Child Abuse and Neglect: The International Journal, Ray Helfer was able only to cite three studies that were adequately controlled in the research area in the last 10 years. One of these was privately supported, and the other two were supported by the NCCAN.

Nor has the research effort funded by NCCAN reflected the multidisciplinary nature of the field. Rather it has focused primarily on the social aspects of the problem with little attention focused on the pediatric, psychiatric or epidemiologic aspects of child abuse and neglect. The Center has failed to develop any interagency efforts with NIMH, NICHD or CDC which would have served to multiply the impact of research efforts. Unfortunately, these other agencies involved with child abuse and neglect systematically decided not to fund related projects, assuming the NCCAN's leadership. As a result we are years behind in our research, prevention and treatment efforts.

It is perhaps our greatest concern that the most important research question -- what is the natural history of abused children -- has never been addressed adequately. We do not know how many of these children grow up and abuse or neglect their own children, or how many are appropriately treated and continue on to lead non-abusing lives. The Center has been curtailed in its ability to pursue this. Obviously, the results of such a study would dramatically affect, if not alter, our prevention and treatment efforts. However, to be done well such a study will demand a collaborative and multidisciplinary approach.

3. Manpower

There is a great need for increased federal leadership in the development of programs to help meet the desperate need of state and local child protective services agencies as they stagger under the weight of enormous increases in the reporting of cases of child abuse and neglect by an increasingly aware public. Our perception is that there is an even greater crisis in child protective service professionals than existed 20 years ago with the lack of primary care physicians. At that time the government recognized the need to develop incentives and training programs for family physicians, pediatricians and other primary care specialties to meet an unmet and growing need. The crisis today for child protective service workers is even greater. Schools of social work do little to train people in child protective services; thus most of these workers are trained on the job. There is also an enormous shortage in mental health professionals and child therapists. It is interesting to note that the Department of Justice has recognized this problem and is encouraging district attorneys to work collaboratively with social work and mental health.

4. Administrative Standing

As you know, the National Center on Child Abuse and Neglect is buried within the enormous bureaucracy of the Department of Health and Human Services. The NCCAN's present position beneath the Office of Human Development Services, Administration on Child Youth and Families and the Children's Bureau, severely inhibits the Center's ability to develop appropriate collaboration with other federal agencies, e.g. NIMH, NICHD, Office of Maternal and Child Health, Head Start, Run Away Youth and Social Services and the CDC. Further, the Center's lack of authority seems to have decreased over the past several years as the Office of Assistant Secretary has assumed even greater responsibility for this area and has attempted to merge the Center's activities into the overall agenda for the Office of Human Development Services. This continued layering of bureaucracy and authority has exacerbated the Center's inability to achieve its goals, as each decision must be cleared and approved by three offices.

V. "BABY DOE"

As you are well aware, the 1984 reauthorization of the federal child abuse law was dominated by debate surrounding treatment issues for seriously ill newborns, the so-called "Baby Doe" issue. After two years of intense controversy and debate, nearly twenty organizations, representing health, disability and anti-abortion issues, and 7 key Senators agreed to language in the child abuse law pertaining to treatment for disabled infants. Specifically the law expanded the definition of medical neglect to include a new category entitled the withholding of medically indicated treatment from disabled infants. The definition described the parameters within which the withholding of treatment, other than appropriate nutrition, hydration and medication, was appropriate, as defined by reasonable medical judgements. The law required states to establish procedures to respond to this category of medical neglect, including identification of a key contact person in the hospitals, and legal authority to pursue these issues as necessary. Compliance with these requirements is necessary for states to receive their share of federal child abuse funds.

A review of state procedures shows that with the exception of California, Pennsylvania and Indiana (the latter two have not taken the federal monies for several years due to legislative issues) all the states enacted procedures which call for immediate or high priority response to such calls. The special monies to help states establish these procedures were used primarily for parent and CPS worker education courses and to pay for medical consultants. Of note, not all the states used, or needed the monies to respond to the new requirements. It must be recalled that the language was intended to build onto existing state procedures and not establish a new CPS system. Thus for some states monies were not required. This does not mean these states were not interested in the issue or failed to comply.

The law also encouraged the creation of hospital review committees to help parents with these difficult decisions. Although such committees were not mandated, it is significant that according to a recent survey which the Academy pursued with the Connecticut Research and Training Center for Pediatric Rehabilitation, University of Connecticut Health Center, most hospitals have or are in the process of establishing such committees. Hospitals surveyed were those with neonatal intensive care units or over 1500 live births annually. The survey reveals two other significant points: 1) committees have been used actively by hospitals; and 2) many of the hospitals which do not have committees use some form of multidisciplinary decisionmaking or refer these cases to a more sophisticated center. The details of the report will be shared with you shortly.

These figures indicate that a significant number of hospitals, within a relatively short period of time, have instituted review committees. Clearly this percentage represents a dramatic change in the way decisions are being made regarding disabled newborns. The Academy has long supported -- and continues to advocate -- the creation of such committees to assist with the decisionmaking process in difficult cases. To this end we have developed a set of guidelines to facilitate the establishment of such committees. Additionally, the Academy has convened a number of seminars, workshops and education courses at Academy meetings to help members with this issue. We believe additional and ongoing education is required in this area.

No discussion of this issue would be complete without mentioning the involvement of this committee and its chairman with these efforts. Despite the difficult path to compromise, you should be pleased to know that the law appears to be working. As such, the Academy along with the National Coalition on Child Abuse and other organizations does not recommend any changes or modifications to this section of the law. The Academy will continue to devote our energies to the successful implementation of this law and to helping physicians, health care professionals and families deal with the ever increasingly difficult biomedical ethical issues.

VI. RECOMMENDATIONS

There is no one "solution" to the problem of child abuse and neglect. Rather, a problem of this complexity and magnitude demands an array of approaches and strategies, involving:

1. IMPROVED COORDINATION BETWEEN THE NCCAN, ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION, DEPARTMENT OF EDUCATION AND THE OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES, THE DIVISION OF MATERNAL AND CHILD HEALTH, DEPARTMENT OF JUSTICE, NATIONAL INSTITUTE ON MENTAL HEALTH, AND BUREAU OF INDIAN AFFAIRS.

   Unfortunately, recommendations such as this for increased cooperation between federal agencies often result in token interagency agreements which are confined to the paper on which they are written. The Academy can not overstate the need for such cooperation. Indeed this theme runs through most of our individual recommendations -- the need for identification, prevention, research and treatment to involve all those agencies and programs which deal with these children and their families. No one agency can deal effectively with this problem -- particularly one as underfunded and seemingly undervalued as the National Center on Child Abuse and Neglect. Rather the Center should serve as the lead agency to direct and coordinate the efforts of all programs in this area.

   This reauthorization bill should look to promoting a "total approach" to child abuse -- emphasizing early identification, intervention through home visits, support services and case management of the families' needs. Hawaii is one example of where such collaboration is working beautifully. In 1984 some clever, progressive thinkers obtained funds for a demonstration project to fund the Hawaii Family Stress Center and Child Health Plan. After being funded for 2 years (at $400,000) the results of Project Healthy Start were dramatic -- a 100 percent reduction in abuse and 87.5 percent reduction in neglect among infants from birth to age one. Notably, this occurred in the county in Hawaii which had previously reported the highest incidence of abuse and neglect. (See attached materials for details.)

   The point is that prevention can be accomplished. But it involves the support of an array of professionals and agencies. The Hawaii model relies upon the concept of a "medical home" and a reinstatement of the community health system that will provide comprehensive primary health services which address all the child's needs. The essentials of an adequate "medical home" include: (1) geographic and financial accessiblity; (2) continuity of care from the prenatal period through early childhood and adolescence; (3) coordination through identification of needs and linkage of the family to services needed by the child; and (4) community orientation of awareness of child health problems and resources within the community. This model also emphasizes the need for a greater emphasis by the NCCAN on health issues as part of their child abuse strategy.

Another related example is the Office of Special Education and Rehabilitative Services (OSERS). The recently enacted P.L. 99-457, Education of the Handicapped Act Amendments, gives states monies to establish systems to provide early intervention services to disabled infants from birth. To date, it appears little attention is being focused on how this program be used to prevent the abuse of these infants -- that is, family and parent support programs to help them better deal with the additional stress of a child with disabilities. Emphasis should be placed on using these programs to help special education teachers identify, and help prevent abuse of these children.

The examples are numerous -- the possibilities endless: efforts with ADAMHA to deal with the substance abusing mothers who neglect their children; the Head Start network to provide a therapeutic environment to three to five year olds, etc.

At a minimum, the reauthorization legislation should require model demonstration programs between the NCCAN and other agencies to facilitate these efforts. Some efforts is this area have already taken place, for example with the OSERS, however these efforts must be expanded. On a broad scale, the legislation might call for the NCCAN or a special task force to develop a model for such linkages. What is clear is that these efforts are not taking place to the degree necessary. Nor can the National Advisory Committee as currently constituted or directed fulfill this function. The Center and the Children's Bureau should be commended for their efforts to elevate this committees importance -- however, the effort that is required to implement such agreements exceeds the power and authority of an advisory committee.

2. ELEVATE THE NCCAN

A portion of the above problem is related to the NCCAN's lowly status within the DHHS Bureaucracy as previously explained. The elevation of NCCAN to a position opposite the Assistant Secretary level (either for Health or Human Services) would permit the interagency cooperation necessary to fulfill the Center's goals and objectives. Such cooperation has not occurred with the present alignment for 16 years, and in the Academy's view cannot occur unless NCCAN has the status necessary to work with NIMH, NICHD, the CDC and the Office of Maternal and Child Health, Head Start, Run Away Youth and Social Service Research efforts.

3. REDESIGN THE RESEARCH EFFORT

The National Center should: 1) Coordinate and fund a collaborative multi-site longitudinal study -- in cooperation with the NIMH, CDC, NICHD, MCH Office -- into questions regarding the natural history of the abused child, e.g. how many are treated effectively, how many grow up to become abusive parents, etc. As such, the grant period should be extended from 3 to 5 years. The agency should be authorized specifically to conduct a four year longitudinal study on child abuse and authorized to more effectively disseminate this information. 2) Encourage the above agencies to sponsor research on prevention of family dysfunction which leads to physical and emotional harm to children; and 3) Conduct more research into the physical diagnosis of sexual abuse and into sexually transmitted diseases and sexual abuse in this population.

4. DEVELOP AN INTENSIVE MANPOWER TRAINING EFFORT

The need for a quick, "crash" course to train child protective service professionals cannot be overstated. The current child protective services system is on the verge of collapse and, without support, the backlash will be staggering. Clearly there needs to be a federal effort to stimulate schools of medicine, social work and mental health to develop programs in the area of child abuse and neglect. This effort should be coordinated with the NIMH, ADAMH and Bureau of Health Manpower.

5. STIMULATE PROGRAMS FOR CHILD TREATMENT

Both public sector and private sector funds must be used more effectively to improve the treatment of abused and neglected children and their families. By collaborating efforts -- and funds -- with other agencies, the NCCAN can leverage its admittedly scarce dollars. For example, the NCCAN should develop a program with the Department of Education to develop therapeutic programs for abused children which could be delivered through the schools. We think the legislative authority for this already exists in P.L.94-142. Joint efforts could be initiated with the Department of Defense to address the unique needs of abused and neglected children who are military dependents. We also encourage the Center to continue its program of matching funds, whereby programs linked to a match are privately supported within three years.

6. INCREASE FUNDING LEVELS

Although the collaboration of efforts and other recommendations detailed above will leverage the NCCAN's funds, there is no question that this agency is consistently grossly underfunded. Despite the dramatic rise in reports of abuse and neglect in almost every state, and the corresponding increase in demands on social service and mental health agencies, the Reagan administration has failed to recommend an increased federal investment to deal with this crisis.

We agree with the recommendations of The National Committee for the Prevention of Child Abuse that P.L. 93-247 be extended for four years; the authorization level be raised from its current level of $43.1 to $50 million; and appropriated levels accordingly raised. We appreciate the constraints and limitations of a Gramm-Rudman era; yet anything less suggests our government's commitment to this area is nothing more than symbolic.

7. ISSUES SURROUNDING CHILDREN WITH DISABILITIES

The Center should:

1) Conduct an incidence study into the numbers of children with disabilities who are being abused. This will require cooperation with the DMCH and OSERS.

2) Develop training programs to help all personnel who routinely interact with disabled children to identify and prevent abuse and access the child protective services system as necessary.

3) Develop and disseminate programs with the DMCH and OSERS for parents at risk of abusing their children which includes stress management and other parenting techniques.

In conclusion, the Academy appreciates the opportunity to testify on this important issue and the Chairman's continued leadership and vigilance to the needs of children. We look forward to working closely with you on this and other issues during the 100th Congress.

CHILD HEALTH CARE PLAN

submitted to the
STATEWIDE HEALTH COORDINATING COUNCIL

prepared by the
HAWAII MEDICAL ASSOCIATION
in cooperation with
HAWAII CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

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CHAPTER VI

Summary, Recommendations, and Future Planning

6.100 Analysis and Overall Strategy of the Child Health Care Plan

Introduction - Child health problems are unique and important for several reasons. These are primarily related to the vulnerability of the infant, the rapid growth in all areas of development during childhood, and the fact that development of optimal health in childhood can prevent other conditions of poor health later in life.

The first few hours of life are the most precarious, and more deaths will occur during that short period of time than will occur during the next twenty years. The first year is also quite vulnerable, as attested by the fact that a major indicator of a community or a nation's general level of health is the infant mortality rate.

Due to the extremely rapid physical, emotional, cognitive and social growth rate of the first several years of life, the young child has special needs, which, if not met can result in less than maximal development of permanent damage.

Meeting the special needs of adolescence is also critical to the development of healthy, productive adults. Successful psycho-social development occuring in adolescence is necessary to the establishment of a sense of identity and self-esteem needed to function as an adult.

Thus a major focus upon child health as a special population is worthwhile and rewarding in terms of promoting development of happy, healthy children now and also as a cost-effective investment of a more healthy, less dependent adult population in the future. That is, early remediation or prevention of problems which may be much more costly later in life, or result in dependency upon public institutions, i.e. the mentally retarded, the mentally ill, the economically dependent and those incarcerated in prisons, is cost effective. All of these dependencies occur at tremendous public expense.

There are particular strengths in the child health services in Hawaii which should be mentioned. Hawaii now has a good immunization program, as evidenced by low incidence of communicable disease among children. The State also has an infant death rate considerably lower than the national rate. The merger of Kapiolani and Children's Hospitals has the potential for strengthening maternal-infant and child health services. A Regional Perinatal Center is already being established. Children's Hospital has several special programs, including a Pediatric Residency Continuity of Care Program, the Child Guidance Clinic and the Hawaii Family Stress Center (a demonstration program for innovative services in child abuse and neglect). The latter program has established a State Council on Child Abuse and Neglect. There is also a Developmental Disabilities Council, which has compiled a comprehensive plan for services to the developmentally disabled. There are Children's Mental Health Teams in each mental health cachement area.

The initial plan will examine child health problems and existing resources, identify gaps in services, establish priorities and make recommendations for a coordinated system of services. The plan will build upon some work already completed or in process in the development of plans for specific problem areas, including developmental disabilities, children's mental health services, maternal infant and child health services, child abuse/neglect services. The plan will advocate for coordination of services, to result in a cohesive system of services from two viewpoints. One of these represents a holistic view of the child, so that all health needs of the individual child can be met in a smooth, unfragmented manner, and the family can utilize services relatively easily. The other viewpoint would reflect a comprehensive system of services on a continuum including early identification and prevention/intervention of health problems, emergency and acute care, follow-up care and rehabilitation services.

Summary of Problem Statements - The infant mortality rate has declined significantly overall but remains disproportionately high among part-Hawaiian and Filipino ethnic groups and in certain geographic areas of the state, usually associated with low-income neighborhoods. Leading causes of infant mortality include congenital anomalies, prematurity, diarrheal disease, septicemia, pneumonia, and "other causes."

A study correlating the incidence of infant mortality, prematurity, illegitimacy, prenatal visits, standard fetal deaths, families below poverty level and families receiving DSSH benefits for 30 geographic areas indicates the relative need of these areas for improved maternal and infant health care. Areas most in need of improved care include Hanalei, Waikiki, Kauaikau, Waimanalo, Lanai, Kalihi Palama, Koolauoloa, South Kona, Waianae, North Hilo, and Molokai.

Many health problems are common to all socioeconomic levels. However, the needs assessment data shows that there are wide variations in indices of pre- and post-natal well being among infants and young children in different geographic areas and ethnic groups in the state. The geographic areas most needing assistance are defined, and they are low-income, underserved areas. The on-going planning effort should look more closely at the children in these areas to find out who these children and families are and why they are underserved. We know that problems of the underserved are related to inequalities of income and resources which create barriers to access and utilization of services.

Leading causes of death among children 1-4 are accidents, infective and parasitic disease, congenital anomalies, and all other diseases. Age 5-14 showed leading causes of death as accidents, malignancies, congenital anomalies and other diseases.

Major organic illness of childhood have been greatly reduced by application of medical science; however, behavioral and physiosomatic illnesses related to socioeconomic aspects of the child's environment are increasing. A total of 32,854 children in Hawaii are suffering from some form of emotional disturbance; 2,746 of these are experiencing severe emotional illness. True incidence of child abuse is unknown and is undoubtedly much higher than that which is reported. 506 new cases were confirmed on Oahu alone from January to July, 1977. Child abuse and neglect are causally related to many other problems including mental retardation, emotional and relationship difficulties, school failure and dropout, status offenses and deliquency.

The prevalence of developmental disabilities in Hawaii includes approximately 6,989 mentally retarded, 618 children with cerebral palsy, 1,209 with epilepsy, and 124 autistic children.

Data on morbidity of children is not substantial. Available data indicates that respiratory conditions, infective diseases, injuries and other acute conditions are leading causes of illness among children. Poor children are less likely to receive medical care and are more likely to become ill. A rubella epidemic was the only communicable disease outbreak. Most children are now immunized against the seven preventable diseases. There is an increasing rate of venereal disease among the 15-19 year old group reflecting an 800% increase in the rate since 1967.

Leading health problems of adolescents include teenage pregnancy, emotional disturbances, substance abuse, dropping out of school, status offenses and juvenile delinquency, and developmental disabilities. This suggests a wide range of problems, many of which are preventable early in life. We need to know who these youth are, where they come from and what kind of health care they grew up with, or without. Are they from the same areas and families as the infants and children with poor health indices? What are the situations of their parents, and what practical approaches might be taken to improve their health status within service systems at an acceptable cost? The questions of cost alone are a critical factor in actual implementation of any plan, as children's services most compete with all other public programs for state and DHEW dollars. We as a society quote such truisms as "children are our most important resource", "children are the future of the nation", but the political reality is that children don't vote. Services for children too often get lost in the political process and become a very low priority for allocation of scarce fiscal resources.

The health status section shows a high correlation between poverty, the health care underserved, and children with health and developmental deficits. The low-income areas evidence the poorest MCH indices, high rates of teenage pregnancies, school dropouts, delinquency and crime etc. While child abuse and substance abuse cut across economic groups, low income families are clearly under greater pressures which precipitate these problems and have less resources with which to cope.

Low income and lack of family resources, which is often linked with race, result in inequality and discrimination in access to health care services. Thus social and economic forces beyond the parent's immediate control create barriers for families who might otherwise care more effectively for their children. Obviously, a health care plan cannot provide social equality and an adequate income for the family, but it can assure access to comprehensive and uninterrupted basic health care for the children of all families, through sliding scale fee mechanisms which provide the same quality serivces to all children regardless of ability to pay. This in the long run will be cost effective because of the many disabilities, physical and social, which can be prevented among the population, which would later become a burden upon the public in costs related to medicaid, public assistance, mental illness, mental retardation and delinquency/crime.

Thus one premise of this plan is that health care resources, particularly primary care, should be developed with priority attention to the underserved who are largely located in low-income areas. A critical related problem which has been identified in under utilization of health services, particularly by low-income, less well-educated and motivated groups. There appear to be at least several reasons for this, including lack of awareness of need for services and use of services on an emergency, episodic basis rather than in a planned way which permits continuity of case. Also, services are often not readily accessible or acceptable to families. One way to effect attitude changes across large segments of the population will be through a broader family life education program in the schools, which begins in elementary grades and focuses upon a wide range of subjects related to health, the family, etc. Accessibility of services in terms of geographic distribution is an area of focus for long-range, in-depth planning. Acceptability of services is related to the manner in which services are provided and is addressed under the medical home. Each individual must be able to seek out a medical home which will support them.

Another premise of the plan is that it will emphasize prevention. Health statistics provide information on both physical and emotional developmental problems with roots in infancy and early childhood. Particularly in view of scarce resources, development of a better integrated system of child health services should give priority to maternal-child health services. Within that context, emphasis will be placed upon prevention and positive developmental aspects of infant and child health, beginning in the prenatal period and with a view to early detection and remediation of all developmental problems.

We need to design a system of health care which truly addresses these problems in the most efficient and economical way. The overall approach of this plan will be to facilitate the development and coordination of an integrated system of services which focus upon the well-being of the child, within the context of the family. This concept will implement the concept that every child will have a "medical home," which provides primary health care services which are comprehensive in a sense of addressing the needs of the whole child. The essential nature of an adequate medical home includes (1) accessibility, both geographical and financial; (2) continuity, i.e. prenatal through early childhood and through adolescence; (3) coordination, which requires identification of needs and linkage of the family to all services needed by the child; and (4) a community orientation, i.e., an awareness of child health problems and resources in the overall community. The "medical home" may be within the context of private practice, maternal-infant care clinics, children and youth clinics, hospital out-patient clinics, and community health centers. All of these modes of service delivery will have to be more comprehensively developed in order to provide a medical home as described above.

A range of preventive health care efforts will be implemented within the framework of the medical home. This will include prenatal screening for all health problems for which high risk is predictable, intensive periodic screening during the first year of life, and annually thereafter until age five. After age five, annual checkups would be conducted for preventive health maintenance.

The Role of the Medical Home in Child Abuse Prevention and Positive Child Development

Calvin C.J. Sia, MD* and Gail F. Breakey, RN, MPH**

The Hawaii Medical Association and the Hawaii Chapter of the American Academy of Pediatrics adopted a Child Health Plan in 1978, which recognized that child health problems are unique and important for several reasons. These are primarily related to the vulnerability of the infant and the rapid growth in the areas of physical, emotional, cognitive, social and language development during this period. Early identification of and intervention with dysfunctions in these areas can prevent later conditions of general poor health, learning disabilities, mental retardation, juvenile delinquency, school dropout and suicides, and behavioral dysfunctions of later life. Because of extremely rapid growth in the first two years of life, the infant has special needs which, if not met, can result in less than optimal development and sometimes in the child's becoming a burden to his or her family and society.

The Child Health Plan stresses prevention in early life, through development of a better-integrated system of child health services. This system of services focuses on the well-being of the child within the context of the family. It centers on the concept that every infant born will have a "medical home" that provides primary health care services, comprehensive in nature, which address the needs of the whole child. The essentials of an adequate "medical home" include (1) geographic and financial *accessibility*, (2) *continuity* of care from the prenatal period through early childhood and adolescence, (3) *coordination* through identification of needs and linkage of the family to services needed by the child, and (4) *community orientation* of awareness of child health problems and resources within the community.

Health care is rendered, for the most part, by an unstructured system that lacks the coordination to provide information, training and direction. The busy practicing physician is often unable to "link" the family successfully to all of the services needed by the child in the critical early infancy period. Perhaps this is due to lack of orientation to community resources, but commonly it is due to a lack of adequate communication and working relationships between public and private agencies and the physician and family. Episodic, fragmented services do not contribute to the successful development of the individual infant and child.

The 1985 Hawaii State Legislature provided funds for a demonstration program that can provide a framework for linking infants at high psycho-social risk with a "medical home," and to support the physician in referring the family to other service resources as needed. This program was funded as part of the state's initiative in prevention of child abuse and neglect.

All children should have a medical home, but for children born to dysfunctional families, the need becomes critical. Child abuse and neglect have long been recognized as significant medical and social problems and recent studies indicate that the consequences of abuse and neglect and the accompanying dysfunctional parenting are of equal or greater concern.

Ray Helfer, MD, co-author of "The Battered Child," has attributed a host of problems of childhood and youth to breakdowns in the parent-child relationship. Highly dysfunctional parenting and chaotic family environments result not only in abuse and neglect but also in problems such as learning disabilities, emotional problems, acting out behaviors, mental illness, some incidence of cerebral palsy or mental retardation related to physical abuse, truancy, substance abuse, runaways, delinquency and crime. These problems hinder youth of our community from becoming productive adults and are also extremely costly in social and financial terms. A vast array of services must be mobilized to correct or deal with these problems, the most costly being the juvenile and adult corrections systems.

Prevention of child abuse and neglect and other forms of dysfunctional parenting becomes most desirable, as often these cause much irreparable damage.

Numerous studies of abusive families have led to the identification of "profiles," or characteristics, of abusive parents. From this information it has been possible to construct screening instruments for use in identifying at-risk families so preventive supportive services can be supplied.

Families are available for widespread, systematic screening only at several points in their lives, including at birth of an infant, when the child enters school and again full cycle at pregnancy.

Data recently analyzed by the director of the Children's Protective Services

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Medical Unit, James Drorbaugh, MD, indicates that about 84% of serious abuse cases and all 14 deaths since 1980 in Hawaii have occurred among children under five years of age. Intervention with at-risk families at birth is essential for this reason, and also because the first few years of life are so critical for healthy child development. Intervention at this time is also probably the most acceptable to the family, as services can be incorporated into routine perinatal services.

The Hawaii Family Stress Center at Kapiolani Women's and Children's Medical Center and Family Support Service projects at hospitals in Hilo, Kona, Maui, Molokai and Kauai have been conducting screening for at-risk families using a checklist developed by E. Henry Kempe, MD. Home visitor services are provided for at-risk families utilizing the lay therapy approach, following Dr. Kempe's model program.

The new demonstration program will be conducted at Kapiolani through the Stress Center.

This project has several goals. The first is to demonstrate effectiveness of early intervention in significantly reducing abuse of infants in one carefully defined geographic area. The second is to "link" the infant and family to a medical home for monitoring of the infant's safety, early and periodic screening in accordance with the HMA and new Medicaid guidelines, referral of the family to needed services, and providing continuity of care during the child's early years of life (i.e. birth to kindergarten).

Following screening, at-risk families will be referred to the project home outreach workers, who will facilitate parent-infant attachment, provide emotional support and assist parents to establish social support systems. Intensive involvement of the worker will continue for the first 12 to 24 months, according to the child's needs, and then taper off to a monitoring function with visits approximately 4 to 6 times a year.

Also, the worker will "link" the family to a "medical home" for the infant. Project professional and paraprofessional staff will maintain contact with the physician to review the child's status and to assist in facilitating needed referrals.

In this way, the physician becomes the case manager for ongoing follow-up; and the project staff provides support as needed, collects data and conducts periodic monitoring until the child enters school.

It is essential that the "medical home" physician develop and maintain awareness of early childhood problems as well as intervention and management skills related to these problems on an ongoing basis.

Project staff also will meet with providers of various services needed by the project families. The purpose of these meetings will be to enhance networking and to define gaps in service. Desired outcomes will be to increase awareness among service providers of the needs of at-risk families and formal documentation of these needs with recommendations on gaps inservices available.

This project will provide an organized system of identifying at-risk families, linking them to the medical home and supporting the physician in carrying out the role of medical management. The project will provide intensive emotional support to the family initially after birth, and then move toward a monitoring function through periodic home visits and contact with the physician.

The overall goal of the project is to demonstrate the effectiveness of the prevention of abuse and the establishment of support networks to promote positive child development for at-risk infants.

If successful, it is hoped that the program will be expanded, as was the pilot School Health Program.

This is a unique opportunity to develop an excellent system of preventive health services for children. Success of the Medical Home concept highlighting early periodic screening and continuity of care for the infant will be key.

AGENCY: Hawaii Family Stress Center
Kapiolani Women's & Children's Medical Center
1319 Punahou Street, Honolulu, Hawaii 96826

PROJECT DIRECTOR: Gail Breakey Area Code: 808 - 947 8225

Contract Date: From 10/1/86 to 10/1/89

PROJECT: FACILITATION OF PRIMARY CARE PHYSICIAN PARTICIPATION IN PREVENTIVE HEALTH CARE OF CHILDREN AGE 0-5 FROM UNDERSERVED, DIVERSE CULTURAL POPULATIONS

Underserved, diverse cultural populations have poorer health characteristics than the general population, and are more at risk for psycho-social and behavioral problems, termed the "new morbidity". These problems are critical for the 0-5 age group who have much greater preventive health care needs than adults and for whom preventive services are most cost-effective. The EPSDT Medicaid program designed to address this problem reaches only 25% of the eligible population for apparently minimal levels of service and attracts limited physician participation.

The health status problem selected includes developmental delays and psychosocial problems of children 0-5 from underserved, culturally diverse populations. Contributing factors to the health status problem are a range of family stresses which result in dysfunctioning parenting. This target group is most at-risk for and most vulnerable to the effects of these conditions. Consequences in terms of impaired functioning in later life and costs are considerable, including substance abuse, school dropout, delinquency, crime, emotional and mental illness which require expensive remedial services.

The project proposes to intervene with this problem by promoting the involvement of the primary care physicians, pediatricians, in early screening and intervention with the target population, based upon the medical home concept and according to American Academy of Pediatrics Health Supervision Guidelines. Contributing factors to present low physician participation in services to this target group include low Medicaid reimbursement, physician experience of Medicaid families being more difficult to work with, a historic pediatric orientation to treating illness rather than providing preventive care, lack of knowledge/awareness re community resources and sense of being part of a community team.

The proposed MCHIP project would be "piggy backed" to Project Healthy Start", which identifies 125 infants/year from low income diverse ethnic families to prevent child abuse and to promote positive child development. The target group will be primarily low income Part-Hawaiian and Filipino children 0-5 of families from an underserved area of : Oahu, Hawaii. The number of children served would be 125-250 in the first project year, 250-375 in the second year and 375-500 in the third year.

A core group of physician leaders who have met with us in planning this MCHIP will assist in a developing baseline data questionnaire related to present physician attitudes and services to the project population; in sponsoring training for physicians related to the "new morbidity", needs of project families, AAP Health Supervision and Guidelines, early screening tools, such as DDST and use of community resources. Healthy Start staff and the core physician group have already successfully lobbied together in obtaining an increase in the Medicaid reimbursement during the 1986 legislative session. MCHIP project health coordinator and two home visitors will conduct quarterly followup with families regarding safety of the home and parent-child interaction, and conduct case conferences with the physician. Small group meeting with physicians, MCHIP staff and core group physicians will focus on project families and issues of preventive care. Evaluation will utilize the same indices used in the baseline data collection, and will be conducted at months at 18 and 30. A dissemination plan is provided. The project should be of national interest and significance in demonstrating a practical approach to services to the 0-5 underserved, culturally diverse children, and as a "missing link" in establishing a comprehensive, integrated system for health care services for this target group.

Senator DODD. Mr. Hollahan, I have less than five minutes to vote. I do not know whether it is the veto override vote itself or the motion to reconsider the vote. I suspect Bob Dole would love it if I stayed here, and Bob Byrd would love it if I made it over there. So I am going to take a recess now and it will probably be for about 20 minutes or so. I do apologize to you. I have some questions for you, and I will try and come back shortly.

So we will take a 20-minute recess subject to the call of the Chair.

[Recess.]

Senator DODD. I would ask the Subcommittee to reconvene. I am going to explain what we are going to try and do here this afternoon.

We are now going to be dealing with the highway bill in bits and pieces, so there will be a series of motions on the Floor. There will be a series of votes all afternoon until some people see the light of day one way or the other, I guess, depending upon your perspective on this issue.

So I will go to you, Mr. Hollahan, and take your testimony. Then what I am going to suggest we do is hear from the Administration, and then we are going to do the questions for everyone all at once. So at least we will get a chance to hear from everybody. I can always submit the questions to you in writing later if we have to do that.

I apologize for this inconvenience, but you never can predict with any certainty what life is going to be like around here.

Mr. Hollahan, we will take your testimony.

Mr. HOLLAHAN. Thank you, Senator.

I am here representing the Consortium of Citizens with Disabilities, a coalition of over 60 national consumer professional provider organizations—but more importantly, the millions of Americans represented by these organizations. I am here on behalf of United Cerebral Palsy Association, Incorporated.

UCP Association is a national network of community providers of services to persons with severe disabilities and has about 180 affiliates in 45 States across the country. Collectively, UCPA spends over $220 million a year providing vital services to people with disabilities.

Child abuse is a problem with immense implications for the overall health and physical well-being of children in particular and the society as a whole. The purposes of my testimony today will be to cover three issues: abuse and neglect as a cause of disabilities, the significant relationship between child abuse and disabilities, and the continuing problem of withholding treatment for disabled infants with life-threatening conditions. I will conclude with a set of recommendations that will focus not only on the need for additional research, but also on prevention efforts to relieve stress in families.

Attached to our testimony is a full copy of a study that United Cerebral Palsy did in 1985. The survey covered 42 affiliates serving 2,771 children with developmental disabilities in preschool programs across the country. The purpose of the survey was to attempt to fill a serious gap in the database nationwide on the connection between child abuse and handicapping conditions. Thirty-eight centers completed the survey and reported that 9.4 percent of the 2,416 children they served had disabilities of a post-natal onset. Analysis of the survey results indicated that in the case of acquired disabilities, 11.9 percent were the result of known abuse, and 12.3 percent were the result of possible abuse.

A second major concern of United Cerebral Palsy and CCDD is the unfortunate and significant relationship between abuse and children who are developmentally disabled. Experts agree that the abused child in the family is often seen as special in some way. A child born prematurely and with some physical disability is singled out as different within the family unit, and as a result is a prime candidate for abuse in a psychologically unstable environment. Such factors as prematurity, low birth weight and physical handicaps can contribute to the negative way a child is viewed by relatives and parents.

Children with physical or mental handicaps are naturally at odds with their environment until they are guided and given the necessary support and assistance. Because of their inability to respond in same manner as other individuals around them, their responses to their environment may reflect feelings of rejection, inadequacy, and poor self-esteem, which can in turn trigger stress-provoked behaviors on the part of others. The more likely target for abuse is the child who is over-reactive or presents problems in physical care. Extra time, patients and understanding may be needed to assist a child with cerebral palsy with feeding, toileting and other self-care skills in the course of a day. The level of care and commitment can be mentally and physically taxing, particularly for a parent who has other children demanding time and attention.

In the 1985 UCP study, Warren and Cohn reported 303 cases of known or possible abuse of children with disabilities. Examples included such things as a child who was physically abused by a father, bite marks from neck to toe—the child was removed from the home and is now in a foster home; an 18-month-old infant with quadriplegia who was removed from a home because of evidence of cigarette burns and extreme hunger.

This most recent study reconfirms the results of other earlier research efforts. A substantial amount of abuse of young children is taking place, some of it causing disabilities and much of it occurring to children who are already developmentally disabled.

No State or national record-keeping is currently tracking the relationship between abuse and disabilities. No specific training in prevention, recognition and reporting of child abuse are called for in all the programs for preschool and school-age children with disabilities. No specific training is required of personnel employed in child protection services to sensitize them to the relationship between abuse and disabilities and to provide them training in effective and appropriate communication techniques with children who are mentally and physically disabled.

We have another concern that three years ago, the Child Abuse Prevention and Treatment Act was amended in response to a growing concern with several highly-publicized incidents of withholding medical treatment for disabled infants in life-threatening conditions.

Each State has had the opportunity to apply for Federal funding to develop, establish and implement programs. The funds can also be used for information, education and training programs targeted to parents and professionals for the purpose of improving the provision and coordination of services to infants with disabilities and their families.

In fiscal year '86, ten States did not even apply for the available funds. Little is known about the status of the implementation of these important amendments. Anecdotal information collected from a number of States indicates very little, if anything, has been done from a prevention aspect. Parents of disabled infants need information to help them obtain information about early intervention and family support services. That is a real important connection and positive part of what that can do.

So our recommendations include, number one, a more adequate database and collection of data, as other members of the panel have reviewed; we also believe there is an urgent need to conduct a national study investigating the correlation between child abuse and developmental disabilities. Obviously, we are concerned about children with disabilities who are abused, but there is new evidence and concern over the growing number of children who are becoming disabled due to abuse.

We would like to also see a national demonstration project developed that would teach educators, child welfare workers, department of health, child protective workers, justice system employees on how to address the specific needs of children with disabilities who are abused. Generally, children with handicaps are less able to defend themselves physically, articulate an abusive incident, and comprehend abusive behavior.

For example, without training, a child welfare worker may not know how to communicate with a child with cerebral palsy who has no understandable speech. Similarly, children with learning disabilities may pose special difficulties for professionals unable to fully understand and appreciate the child's disabling condition.

At the same time, we would also like to see a demonstration grant for children with disabilities to receive specialized education and training on how to protect themselves against abuse, as well as report potential abusive incidents to adults.

We ask that the Committee work to ensure the Children's Justice Act, Public Law 99-401, is funded at the full authorization level of $5 million for respite care demonstration projects and $5 million for crisis nurseries. Respite care is a proven effective strategy to reduce stress and keep families together.

Special protection for handicapped infants. UCP and CCDD applaud the initiative of the Surgeon General to have the Inspector General study the impact of Baby Doe regulations on each State. The conclusion will be studied carefully by us, and we would welcome the opportunity to make recommendations to you at that time. Nonetheless, we would like to state clearly that Baby Doe should remain as a part of the bill while maintaining the intent of the original provisions.

United Cerebral Palsy and the Children's Task Force of CCDD believe that the passage of Senate Bill 249 will provide families of children with disabilities needed support and basic job security.

And Senator Dodd, we want to commend you for the work that you have done for that legislation.

Finally, we are concerned with the Administration's attempt to zero-fund early intervention initiatives passed as a part of the Education of All Handicapped Children Amendments of 1986. With bipartisan support, Congress last year made clear its desire to make early intervention available to all children with developmental disabilities. We ask that you not allow the Administration to gut this important program. And further, we ask that you work to ensure the full funding of early intervention programs.

That concludes my remarks.

Senator **Dodd**. Thank you very, very much.

What I would like to do is continue. We have about 15 minutes left on a vote. So, I am going to ask you, if you can, Dr. Elder, to come to the table so that we can at least get your testimony in. Then I will come back with questions.

Let me reiterate again this is not the normal order of witnesses. So often what happens is the Administration will come up and testify first, and then others testify, and the Administration does not have the benefit of hearing some of the things others say. I realize, given the problems we have on the Floor of the Senate today, this has put a bit of a crimp in everyone's plans. But I want you to know that I appreciate deeply your willingness to wait. I know you are busy. You have an awful lot on your hands as well.

We will hear your testimony in whatever fashion you wish to present it, and then get into some questions. Then I can come back with questions for the other witnesses. I think you have had a chance to listen to most of these people and their comments, and I know a lot of it has been focused on the National Center.

STATEMENT OF DR. JEAN ELDER, SECRETARY FOR HUMAN DEVELOPMENT SERVICES-DESIGNATE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY DODIE LIVINGSTON, COMMISSIONER, ADMINISTRATION FOR CHILDREN, YOUTH AND FAMILIES, AND DR. JANE BURNLEY, ASSOCIATE COMMISSIONER, THE CHILDREN'S BUREAU

Dr. **Elder**. First of all, I would like to introduce my colleagues, Senator. Dodie Livingston, the Commissioner for the Administration for Children, Youth and Families, is sitting to my far left. Dr. Jane Burnley, the Associate Commissioner for the Administration for Children, Youth and Families, is sitting next to me.

I would like to say that I am very happy to have the opportunity to provide an overview of the Office of Human Development Services initiatives and programs that address the problem of child abuse and neglect and also to discuss the Administration's proposals to reauthorize the Child Abuse Prevention and Treatment Act.

I have enjoyed listening to the witnesses of the second panel. I am sorry I could not hear the people on the first panel. I really enjoyed listening to the issues, and certainly, listening to the challenges, the trends, some recommendations, also to some opinion, and to some research concerns from design to the social aspect of this problem. I concur with the good physician who sat at this table that that research is a very important element.

I also was delighted to hear that there is a great deal of interest in a multidisciplinary approach to child abuse and neglect. I commend both my Commissioner and Associate Commissioner for leadership in making some changes in how we are delivering services. I am very proud to hear that discussed at this table.

I was also very intrigued to hear a great deal of discussion about our training needs, our technical assistance needs, and our data needs. I feel very comfortable in saying to you that there is a great deal of common ground.

I would like to also share with you that your concern for the protection of all vulnerable children is also our concern. We truly agree that child abuse and neglect is a tragic national problem.

As has been mentioned by witnesses from the second panel, our awareness and response to the problem of child abuse has grown significantly since the Child Abuse Prevention and Treatment Act was first enacted in 1974. The good news is that all States now have child abuse reporting laws and expanded child protective services. It is very important to note that the public's awareness of child abuse has also grown during this period, increasing from 10 percent in 1976 to 90 percent in 1984.

Consequently as has been previously mentioned, we have experienced an incremental increase in the number of reports of abuse and neglect. In 1985 alone, there were 1.9 million reports of child maltreatment, and approximately 39 percent of these reports were substantiated upon investigation.

Clearly, we look to parents as having the responsibility for protecting their children. Services to assist parents in carrying out this responsibility are best planned and best provided at the local level. The role of the Federal Government is to provide national leadership and to assist States and communities to develop, expand and improve programs to prevent, to identify and to treat child abuse and neglect.

Protecting our children from abuse and neglect is everyone's responsibility. The Government's programs alone will not solve this problem. We must involve families, professionals, communities, the private sector, national and local organizations.

One of the most encouraging developments in recent years is the increased involvement of foundations and the private and corporate sectors in the prevention and treatment of child abuse. Organizations such as the Toy Manufacturers of America, the Southland Corporation, Marvel Comics, the Conrad Hilton Foundation, the Association of Junior Leagues, and the National Federation of Jewish Women, have shown real leadership and commitment to a wide variety of child abuse prevention activities.

The Administration strongly supports the Child Abuse Prevention and Treatment Act. We will shortly propose legislation to reauthorize this law for three years and to improve certain sections of the law.

In pursuit of these goals, some of the features of the Administration's bill are as follows. The bill will allow States that did not meet the original October 9, 1985 deadline for the Baby Doe requirements, but that later had the required procedures in place, to be eligible for grant funds.

Another provision of the bill would amend the Secretary's discretionary authority for demonstration programs and projects to reflect more accurately the types of activities which should be supported in response to current and future service needs. Our proposal will permit interdisciplinary training, technical assistance, service demonstration and evaluation projects.

The National Center for Child Abuse and Neglect, located in the Children's Bureau of the Administration for Children, Youth and Families, serves as the Federal focal point for child abuse and neglect issues and programs. Our implementation of the Federal child abuse program has focused on grants, made directly to States meeting the legislative eligibility requirements, to improve prevention and treatment services, and to develop programs and procedures to respond to reports of withholding of medically indicated treatment for disabled infants with life-threatening conditions. Discretionary grants provide support for research, demonstration, service improvement, information dissemination, clearinghouse and technical assistance activities designed to improve and increase national, State, community and family efforts for the prevention, identification and treatment of child abuse and neglect.

The Children's Justice and Assistance Act of 1986, to be implemented in fiscal year 1987, will provide for grants to assist States in developing, establishing and operating programs designed to improve the handling of child abuse cases, particularly cases of child sexual abuse, in a manner which limits additional trauma to the child victim. Funds may also be used to improve the investigation and prosecution of cases of child abuse, particularly child sexual abuse.

One of the most significant issues in the 1984 Amendments to the Act was the so-called Baby Doe requirements.

Senator DODD. May I interrupt you right there? I have a minute left to vote. Let me go vote, and then we will have a nice half an hour block when I come back.

Dr. ELDER. Very good.

Senator DODD. I will take a five-minute recess.

[Short recess.]

Senator DODD. The Subcommittee will come back to order.

Dr. Elder, I think that is the last vote for a little bit. Bob Dole told me he is going to have a quorum call now, so that will give us a breather and hopefully, we can complete this. I appreciate your patience.

Dr. ELDER. It is no problem. Let me go back and just repeat one sentence.

Senator DODD. Yes, you were on page 6.

Dr. ELDER. I was on page 6, yes. One of the most important issues in the 1984 Amendments to the Act were the so-called Baby Doe requirements. We are proud of our implementation of these provisions, which are designed to ensure that medical treatment and care are provided for disabled infants with life-threatening conditions.

First of all, we published the final Baby Doe regulations and model guidelines for the Infant Care Review Committees in April 1985 as required. We awarded grants to States to assist them to implement these provisions. We reviewed State plans and procedures designed to implement the Baby Doe requirements. All States except three—Pennsylvania, Indiana and California have such provisions in place. We have also awarded funds to the University of South Carolina to establish the National Information and Resource Clearinghouse as required.

In addition, as was previously mentioned, the Office of the Inspector General will conduct a program inspection on the implementation of the Baby Doe provisions of the Child Abuse Prevention and Treatment Act. The purpose of the inspection is to determine whether there are systems in place to protect severely disabled infants with life-threatening conditions as mandated by Public Law 98-457.

The rest of my written testimony lists numerous initiatives and activities that we have undertaken at HDS in order to provide leadership in the field of child abuse and neglect. Our major initiatives have centered on three themes. They are: How can we prevent family disruption and improve family functioning so that child abuse and neglect is prevented? How can we improve the protective service systems so that children at risk are identified and served appropriately? And finally, how can we support the training and professional development of the child protection work force?

In conclusion, we all agree that the problems of child abuse and neglect are complex. We look forward to our continued work with States and communities in addressing these issues and in the protection of our nation's children.

Mr. Chairman, I pledge every effort to communicate with this Committee and work with this Committee to the end that our response as a Nation to the tragic incidence of child maltreatment is appropriate and thus effective.

We would be very happy to answer any questions you might have.

[The prepared statement of Dr. Elder follows:]

STATEMENT BY

JEAN K. ELDER, PH.D.

ASSISTANT SECRETARY FOR

HUMAN DEVELOPMENT SERVICES-DESIGNATE

BEFORE

SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

COMMITTEE ON LABOR & HUMAN RESOURCES

U.S. SENATE

APRIL 1, 1987

Mr. Chairman, Members of the Subcommittee

I am pleased to have this opportunity today to provide an overview of the HDS initiatives and programs that address the problem of child abuse and neglect and to discuss our proposals to reauthorize the Child Abuse Prevention and Treatment Act. I'm especially pleased to have this opportunity on this first day of National Child Abuse Prevention Month.

Mr. Chairman, I share your concern for the protection of all vulnerable children and agree that child abuse and neglect is a tragic national problem.

Our awareness and response to the problem of child abuse has grown significantly since the Child Abuse Prevention and Treatment Act was first enacted in 1974. All States now have child abuse reporting laws and expanded child protective services. The public's awareness of child abuse has also grown during this period, increasing from 10% in 1976 to 90% in 1984.

Consequently, we have seen a continuing increase in the number of reports of abuse and neglect. In 1985, there were 1.9 million reports of child maltreatment. Approximately 39% of these reports were substantiated upon investigation.

WE LOOK TO PARENTS AS HAVING THE RESPONSIBILITY FOR PROTECTING THEIR CHILDREN. SERVICES TO ASSIST PARENTS IN CARRYING OUT THIS RESPONSIBILITY ARE BEST PLANNED AND PROVIDED AT THE LOCAL LEVEL.

THE ROLE OF THE FEDERAL GOVERNMENT IS TO PROVIDE NATIONAL LEADERSHIP AND TO ASSIST STATES AND COMMUNITIES TO DEVELOP EXPAND AND IMPROVE PROGRAMS TO PREVENT, IDENTIFY AND TREAT CHILD ABUSE AND NEGLECT.

PROTECTING OUR CHILDREN FROM ABUSE AND NEGLECT IS EVERYONE'S RESPONSIBILITY. GOVERNMENT PROGRAMS ALONE WILL NOT SOLVE THIS PROBLEM. WE MUST INVOLVE FAMILIES, PROFESSIONALS, COMMUNITIES, THE PRIVATE SECTOR AND NATIONAL AND LOCAL ORGANIZATIONS.

ONE OF THE MOST ENCOURAGING DEVELOPMENTS IN RECENT YEARS IS THE INCREASED INVOLVEMENT OF FOUNDATIONS AND THE PRIVATE AND CORPORATE SECTORS IN THE PREVENTION AND TREATMENT OF CHILD ABUSE. ORGANIZATIONS SUCH AS THE TOY MANUFACTURERS OF AMERICA, THE SOUTHLAND CORPORATION, MARVEL COMICS, THE CONRAD HILTON FOUNDATION, THE NATIONAL ASSOCIATION OF JUNIOR LEAGUES AND THE NATIONAL FEDERATION OF JEWISH WOMEN HAVE SHOWN REAL LEADERSHIP AND COMMITMENT TO A WIDE VARIETY OF CHILD ABUSE PREVENTION ACTIVITIES.

REAUTHORIZATION

THE ADMINISTRATION STRONGLY SUPPORTS THE CHILD ABUSE PREVENTION AND TREATMENT ACT AND WILL SHORTLY PROPOSE LEGISLATION TO REAUTHORIZE THIS LAW FOR THREE YEARS AND TO IMPROVE CERTAIN OUTDATED SECTIONS OF THE LAW.

IN PURSUIT OF THESE GOALS, SOME OF THE FEATURES OF THE ADMINISTRATION'S BILL ARE AS FOLLOWS: THE BILL WOULD ALLOW STATES THAT DID NOT MEET THE ORIGINAL OCTOBER 9, 1985 DEADLINE FOR THE "BABY DOE" REQUIREMENTS, BUT THAT LATER HAVE THE REQUIRED PROCEDURES AND PROGRAMS IN PLACE, TO BE ELIGIBLE FOR GRANT FUNDS.

ANOTHER PROVISION OF THE BILL WOULD AMEND THE SECRETARY'S DISCRETIONARY AUTHORITY FOR DEMONSTRATION PROGRAMS AND PROJECTS TO REFLECT MORE ACCURATELY THE TYPES OF ACTIVITIES WHICH SHOULD BE SUPPORTED IN RESPONSE TO CURRENT AND FUTURE SERVICE NEEDS. OUR PROPOSAL WILL PERMIT INTERDISCIPLINARY TRAINING, TECHNICAL ASSISTANCE, SERVICE DEMONSTRATION AND EVALUATION PROJECTS.

THE DRAFT BILL WOULD ALSO REPEAL THE AUTHORITY FOR FEDERAL CHALLENGE GRANTS TO ENCOURAGE STATES TO ESTABLISH AND MAINTAIN FUNDING MECHANISMS TO SUPPORT CHILD ABUSE AND NEGLECT PREVENTION ACTIVITIES. SINCE MOST STATES HAVE ESTABLISHED TRUST FUNDS OR SIMILAR MECHANISMS TO SUPPORT CHILD ABUSE AND NEGLECT PREVENTION ACTIVITIES, THIS AUTHORITY HAS MORE THAN ADEQUATELY SERVED ITS PURPOSE.

FEDERAL RESPONSE

THE NATIONAL CENTER FOR CHILD ABUSE AND NEGLECT, LOCATED IN THE CHILDREN'S BUREAU OF THE ADMINISTRATION FOR CHILDREN, YOUTH AND FAMILIES, SERVES AS THE FEDERAL FOCAL POINT FOR CHILD ABUSE AND NEGLECT ISSUES AND PROGRAMS. OUR IMPLEMENTATION OF THE FEDERAL CHILD ABUSE PROGRAM HAS FOCUSED ON:

- GRANTS ARE MADE DIRECTLY TO STATES MEETING THE LEGISLATIVE ELIGIBILITY REQUIREMENTS TO IMPROVE PREVENTION AND TREATMENT SERVICES AND TO DEVELOP PROGRAMS AND PROCEDURES TO RESPOND TO REPORTS OF WITHHOLDING OF MEDICALLY INDICATED TREATMENT FOR DISABLED INFANTS WITH LIFE THREATENING CONDITIONS.

- DISCRETIONARY GRANTS PROVIDE SUPPORT FOR RESEARCH, DEMONSTRATION, SERVICE IMPROVEMENT, INFORMATION DISSEMINATION, CLEARINGHOUSE, AND TECHNICAL ASSISTANCE ACTIVITIES DESIGNED TO IMPROVE AND INCREASE NATIONAL, STATE, COMMUNITY AND FAMILY EFFORTS FOR THE PREVENTION, IDENTIFICATION AND TREATMENT OF CHILD ABUSE AND NEGLECT.

- THE CHILDREN'S JUSTICE AND ASSISTANCE ACT OF 1986, TO BE IMPLEMENTED IN FY 1987, WILL PROVIDE FOR GRANTS TO ASSIST STATES IN DEVELOPING, ESTABLISHING, AND OPERATING PROGRAMS DESIGNED TO IMPROVE THE HANDLING OF CHILD ABUSE CASES, PARTICULARLY CASES OF CHILD SEXUAL ABUSE, IN A MANNER WHICH LIMITS ADDITIONAL TRAUMA TO THE CHILD VICTIM. FUNDS MAY ALSO BE USED TO IMPROVE THE INVESTIGATION AND PROSECUTION OF CASES OF CHILD ABUSE, PARTICULARLY CHILD SEXUAL ABUSE.

IMPLEMENTATION OF "BABY DOE" REQUIREMENTS

ONE OF THE MOST SIGNIFICANT ISSUES IN THE 1984 AMENDMENTS TO THE ACT WAS THE SO CALLED "BABY DOE" REQUIREMENTS. WE ARE QUITE PROUND OF OUR IMPLEMENTATION OF THESE PROVISIONS WHICH ARE DESIGNED TO ENSURE THAT MEDICAL TREATMENT AND CARE ARE PROVIDED FOR DISABLED INFANTS WITH LIFE THREATENING CONDITIONS:

- WE PUBLISHED THE FINAL BABY DOE REGULATIONS AND MODEL GUIDELINES FOR INFANT CARE REIVEW COMMITTEES IN APRIL 1985 AS REQUIRED.

- WE AWARDED GRANTS TO STATES TO ASSIST THEM TO IMPLEMENT THESE PROVISIONS

- WE REVIEWED STATE PROGRAM AND PROCEDURES DESIGNED TO IMPLEMENT THE BABY DOE REQUIRMENTS. ALL STATES EXCEPT PENNSYLVANIA, INDIANA, CALIFORNIA HAVE SUCH PROVISIONS IN PLACE.

- WE HAVE ALSO AWARDED FUNDS TO THE UNIVERSITY OF SOUTH CAROLINA TO ESTABLISH THE NATIONAL INFORMATION AND RESOURCE CLEARINGHOUSE AS REQUIRED.

- IN ADDITION, THE OFFICE OF THE INSPECTOR GENERAL (OIG) WILL CONDUCT A PROGRAM INSPECTION ON THE IMPLEMENTATION OF THE "BABY DOE" PROVISIONS OF THE CHILD ABUSE PREVENTION AND TREATMENT ACT. THE PURPOSE OF THE INSPECTION IS TO DETERMINE WHETHER THERE ARE SYSTEMS IN PLACE TO PROTECT SEVERLY DISABLED INFANTS WITH LIFE-THREATENING CONDITIONS MANDATED BY P.L. 98-457.

INITIATIVES AND ACTIVITIES

NOW I WOULD LIKE TO HIGHLIGHT SOME OF THE INITIATIVES AND ACTIVITIES WE HAVE UNDERTAKEN AT HDS IN ORDER TO PROVIDE LEADERSHIP IN THE FIELD OF CHILD ABUSE AND NEGLECT.

OUR MAJOR INITIATIVES HAVE CENTERED ON:

1. HOW WE CAN PREVENT FAMILY DISRUPTION AND IMPROVE FAMILY FUNCTIONING, SO THAT CHILD ABUSE AND NEGLECT IS PREVENTED;

2. HOW WE CAN IMPROVE THE PROTECTIVE SERVICES SYSTEM, SO THAT CHILDREN AT RISK ARE IDENTIFIED AND SERVED APPROPRIATELY; AND

3. HOW WE CAN SUPPORT THE TRAINING AND PROFESSIONAL DEVELOPMENT OF THE CHILD PROTECTION WORKFORCE.

o ENCOURAGING PREVENTION OF ABUSE AND NEGLECT THROUGH FAMILY BASED SERVICES

INSTEAD OF REMOVING CHILDREN FROM THEIR HOMES, HDS IN ACCORDANCE WITH THE PROVISIONS OF THE ADOPTION ASSISTANCE AND CHILD WELFARE ACT OF 1980 (THAT ALSO FOCUSES ON PREVENTIVE SERVICES), HAS ENCOURAGED STATES TO REDIRECT THEIR EFFORTS AND RESOURCES FROM REMOVING THE CHILD FROM THE HOUSE TO SUPPORTING FAMILIES TO ALLOW THE CHILD TO REMAIN IN THE HOME WHENEVER POSSIBLE. HDS HAS INITIATED A VARIETY OF ACTIVITIES TO PROVIDE LEADERSHIP AND ASSISTANCE TO THE STATES. SOME EXAMPLES WHICH ARE DESIGNED TO STRENGTHEN THE USE OF HOME BASED SERVICES ARE:

-- ACYF'S NATIONAL RESOURCE CENTER ON FAMILY BASED SERVICES: THE RESOURCE CENTER HAS CONDUCTED STATEWIDE TRAINING AND PROVIDED TECHNICAL ASSISTANCE ON FAMILY BASED SERVICES IN MORE THAN 40 STATES AND IS DISSEMINATING RESOURCE MATERIALS TO THOSE STATES INTERESTED IN PASSING LEGISLATION, DEVELOPING PROGRAMS, STANDARDS FOR SERVICES, OR OTHER ACTIVITIES TO FACILITATE FAMILY BASED SERVICES.

THE CENTER'S APPROACH TO FAMILY BASED SERVICES IS CHARACTERIZED BY A CAREFUL ASSESSMENT OF THE ENTIRE FAMILY, IDENTIFYING BOTH STRENGTHS AND WEAKNESSES FROM WHICH A CASE PLAN IS DEVELOPED JOINTLY BY THE FAMILY AND THE WORKER. MOST SERVICE DELIVERY IS IN THE FAMILY HOME OVER A RELATIVELY SHORT TERM, FREQUENTLY THREE MONTHS OR LESS. SUCH SERVICES HAVE BEEN FOUND TO BE VERY EFFECTIVE IN PREVENTING THE NEED FOR OUT OF HOME PLACEMENT, AND IN REDUCING RISKS TO CHILDREN.

-- PREVENTIVE SERVICE DEMONSTRATION GRANTS. IN FY 1985 AND 1986, HDS FUNDED PREVENTIVE SERVICE DEMONSTRATION GRANTS TO NEW MEXICO, ILLINOIS, MINNESOTA, DELAWARE AND PUERTO RICO. THESE GRANTS ARE FOCUSING ON SUCCESSFUL PRACTICES TO IDENTIFY CHILDREN AT RISK OF REMOVAL FROM THEIR HOMES, AND TO PROVIDE SERVICES TO ENABLE THEIR FAMILIES TO PROVIDE ACCEPTABLE PROTECTION AND CARE.

-- PREVENTION OF ABUSE AND NEGLECT AMONG TEENAGE PARENTS. IN FY 1986, 29 DEMONSTRATION PROJECTS WERE FUNDED TO REPLICATE SUCCESSFUL MODELS FOR HELPING TEENAGE PARENTS IN LOW INCOME COMMUNITIES AND INNER CITY NEIGHBORHOODS BECOME MORE EFFECTIVE IN THEIR PARENTING ROLES BY ENSURING THAT THEY AND THEIR CHILDREN RECEIVE NEEDED

MEDICAL AND SOCIAL SERVICES, AND THAT THE DEVELOPMENTAL NEEDS OF THE CHILDREN ARE MET. IN ADDITION, THESE PROJECTS ARE RESPONSIBLE FOR DEVELOPING PREVENTION PROGRAMS, SUPPORTING SERVICES AND METHODS TO DISSEMINATE CHILD ABUSE AND NEGLECT PREVENTION MATERIALS THROUGH STATEWIDE AND LARGE METROPOLITAN HEALTH AGENCIES. ADDITIONAL PROJECTS WILL BE FUNDED THIS FISCAL YEAR.

o IMPROVING CHILD PROTECTIVE SERVICES

WITH THE LARGE NUMBER OF CASES BEING REPORTED, AGENCIES ARE CONFRONTED WITH THE HIGH EXPECTATIONS OF THE PUBLIC, INCREASED DEMAND FOR SERVICES, AND THE INCREASING COMPLEXITY OF CHILD PROTECTION ISSUES. IN ORDER TO PROVIDE LEADERSHIP TO THE FIELD, WE HAVE INITIATED SEVERAL ACTIVITIES TO IMPROVE THE CHILD PROTECTIVE SERVICES SYSTEM. FOR EXAMPLE:

-- IN FY 1986, WE FUNDED 17 PROJECTS ADDRESSING ALTERNATIVE TREATMENT APPROACHES TO CASEWORK COUNSELLING, INCLUDING USE OF PARAPROFESSIONALS, HOME VISITORS AND A VARIETY OF OTHER COMMUNITY BASED SUPPORT. IN ADDITION, WE PUT A SPECIAL EMPHASIS ON HIGH RISK OR MEDICALLY FRAGILE INFANTS AND YOUNG CHILDREN, BELIEVING THAT THEY WERE AT SPECIAL RISK OF ABUSE OR NEGLECT. THIS YEAR, WE WILL BE

FUNDING A NUMBER OF PROJECTS TO DEVELOP COST-EFFECTIVE COMPENSATING SUPPORT SYSTEMS FOR CHRONICALLY NEGLECTING AND DEPENDENT FAMILIES, USING RESOURCES SUCH AS VOLUNTEERS, PARENT AIDES AND HOME VISITORS, TO HELP THE FAMILY IDENTIFY AND SUSTAIN THE KINDS OF SERVICES AND RESOURCES NEEDED TO KEEP THE FAMILY INTACT WHILE DEPENDENT CHILDREN ARE IN THE HOME.

-- WITH THE RECENT RISE IN REPORTS OF CHILD SEXUAL ABUSE CASES, WE HAVE FOCUSED SEVERAL MILLION DOLLARS IN THE AREA OF PREVENTION. CHILD SEXUAL ABUSE CURRICULA, APPROPRIATE FOR PRESCHOOL, ELEMENTARY AND HIGH SCHOOL STUDENTS, ARE NEARING COMPLETION. IN ADDITION, WE HAVE SUPPORTED THE DEVELOPMENT OF PUBLIC AWARENESS MATERIALS AND 17 DEMONSTRATION PROJECTS AROUND THE COUNTRY WHICH TRAIN SCHOOL PERSONNEL AND STUDENTS OF ALL AGES IN CHILD SEXUAL ABUSE AWARENESS AND PREVENTION.

-- BECAUSE OF THE COMPLEXITY OF OUT OF HOME ABUSE CASES AND CHILD SEXUAL ABUSES CASES, WE HAVE AWARDED 13 GRANTS TO STATES AND COMMUNITIES TO DEVELOP A COORDINATED RESPONSE WHICH INVOLVES CHILD PROTECTIVE SERVICES (CPS), LAW ENFORCEMENT, AND MENTAL HEALTH PERSONNEL AND THE JUDICIAL SYSTEM. THROUGH THESE GRANTS AND THROUGH A

NUMBER OF OTHER MULTIDISCIPLINARY SERVICE AND TRAINING PROJECTS. STATES AND COMMUNITIES ARE EXPANDING AND INTEGRATING SERVICES TO INVOLVE ALL THE NEEDED AGENCIES IN A CHILD PROTECTIVE SERVICES SYSTEM WHICH EXTENDS BEYOND CHILD PROTECTIVE SERVICES.

-- ANOTHER AREA OF MAJOR EMPHASIS HAS BEEN INCREASING THE INVOLVEMENT OF VOLUNTEERS IN CHILD ABUSE PREVENTION AND INTERVENTION. WE HAVE SUPPORTED THE ESTABLISHMENT OF 35 COURT APPOINTED SPECIAL ADVOCACY (CASA) PROGRAMS AROUND THE COUNTRY IN THE PAST 2 YEARS. CASAS ADVOCATE FOR ABUSED AND NEGLECTED CHILDREN INVOLVED IN COURT ACTION. OTHER VOLUNTEERS HAVE SERVED AS PARENT AIDES OR PROVIDED RESPITE CARE.

-- IN JANUARY 1985, THE DEPARTMENT ISSUED THE MODEL CHILD CARE STANDARDS ACT: GUIDANCE TO STATES TO PREVENT CHILD ABUSE IN DAY CARE FACILITIES IN ORDER TO ASSIST STATES IN DEVELOPING STANDARDS AND PROCEDURES TO PREVENT CHILD ABUSE IN DAY CARE SETTINGS. ALSO IN 1985, ACYF RELEASED A PUBLICATION "RECRUITMENT AND SELECTION OF STAFF: A GUIDE FOR MANAGERS OF PRESCHOOL AND CHILD CARE PROGRAMS" TO HELP CHILD CARE PROGRAMS SCREEN EMPLOYEES AND

MAINTAIN HEALTH, SAFE ENVIRONMENTS FOR CHILDREN. A BROCHURE, CHILD SEXUAL ABUSE PREVENTION: TIPS TO PARENTS, DEVELOPED BY THE NATIONAL CENTER FOR CHILD ABUSE AND NEGLECT TO ALERT PARENTS ABOUT HOW THEY CAN FURTHER PROTECT CHILDREN, CONTINUES TO BE WIDELY DISSEMINATED.

-- ANOTHER EXAMPLE OF HOW WE ARE IMPROVING THE CHILD PROTECTIVE SERVICES SYSTEM IS BY DEVELOPING BETTER INSTRUMENTS TO IDENTIFY RISK. BUILDING ON A PROJECT WITH THE AMERICAN BAR ASSOCIATION (ABA) AND THE NATIONAL LEGAL RESOURCE CENTER WHICH EXAMINED HOW DECISIONS WERE MADE IN CHILD INTAKE AND INVESTIGATION, WE ARE NOW FUNDING THE ABA TO FIELD TEST A RISK ASSESSMENT INSTRUMENT WHICH CAN BE USED BY INDIVIDUALS MAKING DECISIONS ABOUT THE DEGREE TO WHICH CHILDREN ARE AT RISK.

o SUPPORTING TRAINING AND PROFESSIONAL DEVELOPMENT TO THE WORKFORCE INVOLVED IN CHILD PROTECTION

WHILE THE PUBLIC'S EXPECTATIONS OF THOSE CHARGED WITH PROVIDING PROTECTIVE SERVICES ARE VERY HIGH, THE INCREASED DEMAND FOR SERVICES AND THE COMPLEXITY OF THE ISSUES INVOLVED STRAIN THE CAPACITY OF THE CHILD PROTECTIVE

AGENCIES. WORKERS ARE CONTINUALLY CONFRONTED WITH THE DIFFICULT TASK OF DETERMINING WHETHER ABUSE HAS TAKEN PLACE, ASSESSING THE POTENTIAL FOR FURTHER ABUSE OR PROGRESS OF TREATMENT, AND DECIDING WHETHER OR NOT TO REMOVE THE CHILD FROM THE HOME OR RETURN THE REMOVED CHILD TO THE FAMILY. TO DEAL EFFECTIVELY WITH THESE ISSUES REQUIRES A MULTIDISCIPLINARY RESPONSE INVOLVING SOCIAL WORK, PEDIATRICS, LAW, PSYCHOLOGY, PSYCHIATRY, NURSING, EDUCATION, PUBLIC HEALTH AND OTHER DISCIPLINES. DESPITE THE INCREASED COMPLEXITY OF THE SERVICE ISSUES, FEW WORKERS ENTER THE FIELD WITH THE PROFESSIONAL TRAINING OR PREPARATION REQUIRED FOR THIS COMPLEX AND DEMANDING JOB. TRAINING PROGRAMS HAVE NOT KEPT PACE WITH THE DEMAND FOR EXPERTISE AND FEW INTERDISCIPLINARY ACADEMIC PROGRAMS EXIST WHICH PROVIDE THE COMPREHENSIVE PROFESSIONAL TRAINING THAT IS NEEDED. EXAMPLES OF HDS ACTIVITIES TO ADDRESS THESE PROBLEMS INCLUDE THE FOLLOWING:

-- CHILD ABUSE AND NEGLECT INTERDISCIPLINARY TRAINING

HDS INTENDS TO FUND TEN INSTITUTIONS OF HIGHER EDUCATION TO ESTABLISH INTERDISCIPLINARY GRADUATE TRAINING PROGRAMS SPECIALIZING IN TREATMENT OF CHILD ABUSE AND NEGLECT. THESE PROGRAMS WILL ENABLE STUDENTS SKILLED IN

A SINGLE DISCIPLINE TO LEARN THE CONCEPTS, TOOLS AND PERSPECTIVES OF RELATED DISCIPLINES THROUGH INTERDISCIPLINARY COURSE WORK AND CLINICAL EXPERIENCES. TRAINING METHODS WILL CONCENTRATE ON CHILD ABUSE AND NEGLECT PREVENTION, IDENTIFICATION, DIAGNOSIS AND TREATMENT.

-- Resource Centers

Increased reporting and high rates of staff turnover have diminished the capacity and effectiveness of the child protective services agencies in the area of intervention and treatment. To enable public and private agencies to respond more effectively, HDS has funded two National Resource Centers on Child Abuse. The American Humane Society's Resource Center focuses on improving the protective service system through resource development, and the Kempe Resource Center focuses on clinical aspects of child abuse.

-- COORDINATION

HDS CO-SPONSORED WITH THE NATIONAL ASSOCIATION OF SOCIAL WORKERS (NASW) AN INVITATIONAL CONFERENCE IN MARCH 1986 WHICH INCLUDED DEANS OF SCHOOLS OF SOCIAL WORK, PRACTITIONERS IN CHILD WELFARE, AND ADMINISTRATORS OF PUBLIC CHILD WELFARE AGENCIES. THE PURPOSE OF THE CONFERENCE WAS TO DEVELOP A PLAN OF ACTION TO EXPAND THE NUMBER OF PROFESSIONALLY TRAINED AND QUALIFIED INDIVIDUALS WHO HAVE A COMMITMENT TO PROVIDING SERVICES IN THE PUBLIC CHILD WELFARE SECTOR. AS A RESULT, WE HAVE REVIEWED THE CHILD WELFARE TRAINING GRANT PROGRAM TO PROVIDE MORE OPPORTUNITIES FOR AGENCIES TO COLLABORATE WITH SCHOOLS AND PROFESSIONAL ASSOCIATIONS INVOLVED IN PUBLIC CHILD WELFARE AROUND SPECIFIC OBJECTIVES. THESE INCLUDE UPGRADING OF STATE AND/OR LOCAL MERIT SYSTEM PROCEDURES FOR CLASSIFYING PROFESSIONAL SOCIAL WORK POSITIONS, DEFINING COMPETENCIES NEEDED FOR CHILD WELFARE AND CHILD PROTECTIVE SERVICES PRACTICE, DEVELOPING RELEVANT CURRICULUM, AND ADDRESSING RECRUITMENT AND RETENTION PROBLEMS IN PUBLIC CHILD WELFARE AGENCIES.

IN CONCLUSION, WE ALL AGREE THAT THE PROBLEMS OF CHILD ABUSE AND NEGLECT ARE COMPLEX AND A CAUSE FOR CONTINUING CONCERN AND FOCUS. WHILE THERE HAS BEEN TREMENDOUS CHANGE IN THIS FIELD IN THE PAST DECADE, AND MORE IS ON THE HORIZON, THIS IS A CRITICAL PERIOD FOR THOSE WORKING IN THE FIELD OF CHILD ABUSE AND NEGLECT ON BEHALF OF CHILDREN. WE LOOK FORWARD TO OUR CONTINUED WORK WITH STATES AND COMMUNITIES IN ADDRESSING THESE ISSUES AND IN THE PROTECTION OF OUR NATION'S CHILDREN. AND MR. CHAIRMAN, I PLEDGE EVERY EFFORT TO COMMUNICATE WITH THIS COMMITTEE AND WORK WITH THIS COMMITTEE, TO THE END THAT OUR RESPONSE AS A NATION TO THE TRAGIC INCIDENCE OF CHILD MALTREATMENT IS APPROPRIATE AND THUS EFFECTIVE.

I WILL BE HAPPY TO ANSWER QUESTIONS.

Senator **Dodd**. Thank you very, very much. I appreciate your testimony this afternoon, Dr. Elder. Many of the comments included in your testimony, certainly, I support entirely.

Let me, if I can, ask you a few things. As you know, a year or two ago, I authored the legislation which created the Challenge Grants on child abuse prevention. They were designed with a sunset provision of five years, the theory being that you could give States enough time to build up enough of a fund so that it would become a revolving fund, to deal with educational programs in their respective States.

You may recall that at the time we authored the legislation, there were some 10 or 15 States that already had grants in place. There are now some 40 States that have those Challenge Grants in place—some have just begun; some are arguably getting near the end of five years, and are building up enough funds, and some are somewhere in-between.

I have been told that part of the Administration's proposal would be to repeal that particular program. I did not see that in this draft of your testimony, so you correct me if I am wrong. I do not believe you were involved, but we had difficulty for a while getting the regulations out on the Challenge Grant program. In fact, the States were getting ahead of us, really wanting to get these things done. And we were having a difficult time getting the Department to come out with the regulations so that we could set up a system that was workable. Obviously, this involved a piece of legislation that had been signed into law and adopted, in fact, with strong bipartisan support—I think it was adopted on a voice vote in the Congress. There was not any fight over it at all. And yet we had to wait an awful long time, for whatever reasons, before we got that thing under way.

I am wondering if you might tell me where—where the Administration is with respect to that proposal. The States want to know the Administration's position, obviously.

Dr. **Elder**. Okay. Let me begin, and then I would ask both the Commissioner and the Associate Commissioner to please add anything they would like to add.

It is my understanding that there are 42 States that have established Children's Trust Funds under the Challenge Grant legislation. And as you already have pointed out to us, the purpose of that program was to encourage States to establish and maintain some type of a trust fund or other funding mechanism to support child abuse and neglect prevention activities. And in putting together our package to come up to the Hill, we looked at the information, saw that we had 42 States that had established trust funds, and with that as an information base, we really believed that the purpose of the legislation had been met, and that further Federal incentive funds to States really were no longer necessary.

Senator **Dodd**. So the Administration will take the position of repealing that?

Dr. **Elder**. Yes, sir—in '88.

Senator **Dodd**. Yes, it will be next year. Obviously, we will have to deal with that this year as part of it.

Dr. **Elder**. Right.

Senator Dodd. Well, I am sorry to hear that because as I point out, a lot of States are not anywhere near completing the five years at all. Based on the evidence we have received from them and testimony you heard today from people in the field who are not partisan at all on these questions, the Challenge Grants have worked very, very well. Obviously, as the author of the bill, I am delighted to hear of the success of the program. But that is not the important point. The point is, is the program still working? If it is not working, I would also be the first one to tell you to try something else. But if it seems to be, I would hope that the Administration might reconsider their request to repeal it.

The Challenge Grant program is tailormade for this President, not in specific terms of child neglect or abuse, but in terms of involving States and localities. Under this program, States spend four dollars for every one spent by the Federal Government. Particularly in States that are hard-pressed, that is a lot of State money. With Federal incentives, child abuse prevention programs are being supported in States that can hardly afford it today. The farm State areas, the Southwest, the South—that are strapped economically, and the fact that their State legislatures, and their Governors are supporting these programs as a priority issue indicates the strong determination to continue Federal incentives so that we make progress. I think the fact that the Federal Government has set up a regulatory scheme on this ties in to your own testimony, that is, the need to a coordinate efforts.

I realize a lot of these decisions are not ones that you make entirely on your own; but you have input, obviously. You are highly respected as a professional, particularly in early childhood development, which I know is an area of real expertise for you. I would urge you today to go back and do your best to see if you cannot get some people to rethink this thing a little bit. I will wait to hear specifically your success. Hope springs eternal, I guess, in my case, so I will continue to try.

The other question I want to focus on involves the National Center, which you have talked about. Obviously, that is a very important focus. The Center is really the only focus we have at the Executive Branch level specifically dedicated to child neglect and abuse. And many people, including the Chairman of this Subcommittee, raise the question of why we do not have an executive director for the Center. That speaks volumes to a lot of people who question whether or not the Administration is really committed to this issue. I happen to believe you are. I think you know enough about the issue that it would be ridiculous to suggest you were not. But there is the concern in the field that we are getting a lot of talk about child abuse, but a real absence of commitment to doing anything about it. And the fact that the Center does not have an executive director is a piece of evidence I hear everywhere I go, as I am sure you hear as well. The question remains, if you are really committed to the Center, why don't you have an executive director? Maybe you would care to take a minute and just explain what the problem is there. Maybe it is not a problem and is going to be addressed.

Ms. Livingston. I have been kind of surprised to hear some of the comments in the field, filtering back, about the directorship of the National Center, because I think there has been a misinterpretation.

Helen Howarton is the Director of the Center. She is a woman of many talents. We have asked her—because we are launching the 75th anniversary celebration of the Children's Bureau—as you know, we mentioned that this morning—which is a really important event in our life at HHS, but also in the field, because this is an historic agency that got this whole interest in kids really focused 75 years ago——

Senator DODD. Dodie, I have to interrupt you. I mean, I appreciate what you are saying——

Ms. LIVINGSTON. We have detailed Helen to organize that event for only three months, possibly four months. And Jane is serving as the Acting Director in the interim, and then we go back to normal.

Senator DODD. Well, I appreciate that. But you have got to appreciate as well——

Ms. LIVINGSTON. Yes, I hear what you are saying.

Senator DODD [continuing]. That you are having an anniversary event, and you are taking away the Executive Director of a program that is extremely important. I cannot believe, with the wealth of talent that exists throughout the Federal Government, that we cannot find someone to handle an anniversary party.

Ms. LIVINGSTON. Well, the anniversary is more than just a party, but I do hear what you are saying.

Senator DODD. I understand.

Ms. LIVINGSTON. But I guess we feel we were misinterpreted a little bit on that.

Senator DODD. Well, I knew about the anniversary event. And when I said you did not have a director, I realized she had been detailed to other duties. That is what I meant. What a lot of Members do up here is to get a letter of objection. They then go out, shop around on the Floor, and get 50 Senators to sign that letter. The letter then gets sent to someone in the Administration, and it just creates a lot of letter-writing going back and forth.

I am here alone today, but let me urge you—and I would urge you—let us get The Director of the Center back on the job. Let's avoid the kind of bureaucratic mess we will go through if you fail to get a Director. Because this is the kind of thing you will find bipartisan support for. Neither Republicans nor Democrats are going to understand failure to act. So, I would urge you today to send the Director back and see if you cannot find someone else for 3 months to detail to the Anniversary celebration. The Center is far too important, and right now, when we are going to talk about the reauthorization, I frankly need someone there. If we are going to do this well by working together to come up with a bill, I would like to have someone on duty there. I need a Director that I can deal with and my staff can deal with so that we can put together a good bill—hopefully, one that we will all agree on.

Dr. BURNLEY. Senator Dodd, I would be glad to work with you at any time, and I think very soon you will in fact see the Administration's reauthorization bill, and we would be glad to work with you on it. We have spent a lot of energy within the Department, in The Children's Bureau, to identify the areas of the bill which could be improved, and I personally took part in that and would look forward to working with you on that.

Senator DODD. Dr. Burnley, I do not question that. I am going to tell you right now, though, just by sheer politics, that this is not the kind of thing you can win on. We may not agree on other things, but if you are going to have the Center's Director dedicated to spending time on an anniversary celebration at a time when we ought to be reauthorizing the child abuse program, it is going to create a problem for you. I would urge you to do it the other way. Now, you can tell me just to go fly a kite, and we can go that route, too. But I am suggesting to you that there is no reason for that. There is no reason for this disagreement, in my mind.

And I have just been told here that you are leaving; is that true?

Dr. BURNLEY. Eventually, we all leave.

Senator DODD. Are you leaving?

Dr. BURNLEY. Yes, sir. I will be leaving sometime toward the end of this month.

Senator DODD. Well, that is ridiculous. Why didn't you tell me that?

Dr. BURNLEY. To tell you the truth, it was not on my mind. Yes, sir, I will be leaving.

Senator DODD. You see, I am not a hard guy to get along with in these things. And I am not trying to be obstreperous at all when I make these recommendations and suggestions. They are things you hear from me in a mild way; believe me, you hear from other people in far less mild ways, as you know. So what I am suggesting here are some things that I think are positive suggestions and not ones meant to be critical at all.

Let me move on. The issue of the fatalities, obviously, is a major question. You know, Dr. Elder, that today I suggested a Presidential Commission. Now, I do not expect you to sit here and say, "That is a great idea, and I endorse the idea," obviously. But I would like you to at least suggest to me how you think we might standardize reporting procedures. You pointed this out in your testimony, and I commend you for that testimony.

You have heard from other people today that we have 11 States that we do not get any data from. Other States, do not want to admit in many cases that they have a real problem because they feel it is an admission that they are not doing their job. So it becomes difficult to get the hard data.

And I think the major problem we have faced on this issue is that there has been a lot of hyperbole. We find out that in fact the issue does not get properly addressed because people exaggerate statistics and then they find out they are false. Then people begin to believe that really, this problem is not there, and you get into a mess. Both of us have seen that in past.

I want to avoid that. I think it is really important we get as good a database as possible. And I wonder what you might suggest.

Dr. ELDER. Senator, I had the good fortune of picking up your testimony when I came up to the Hill today, and I was really very pleased to see your focus on the causes and remedies for this childhood death issue. And as I read it very rapidly, I saw three themes—and forgive me if they are not exact. But the first thing I heard in your testimony was a real concern about infant mortality.

Senator **Dodd**. Right.

Dr. **Elder**. And I think it is really important when we think about that to be very aware of what maternal and child health is doing in that area and how we could tie in with it so that it is not duplicative, and to be sure that we are real clear about what the public health objectives are as we look toward the year 2000, and make certain they are on the mark.

The second theme that I heard was your concern about accidental and nonaccidental deaths within our teenage population, 13 to 19, the suicides and homicides and the accidents. I am hopeful that you have heard a little bit about what we are trying to do with an initiative that we have called Youth 2000 that our good Secretary, Secretary Bowen, working with Secretary Brock from Labor, started last June. We are also bringing the private sector in with us. The National Alliance for Business has been very involved. We are trying to focus on a very comprehensive overview of some of these issues that we all have to deal with when we look at the 15 percent of our youth population that are in great difficulty. This teenage death issue is one that is very serious. It does not matter what magazine you pick up, you certainly see some evidence of that.

Again, there is a public health aspect that is very important that we have to tie in.

The third theme that I heard was an interest on your part and on the Committee's part on looking at the correlation between the abuse issue and then the deaths. I hear you in terms of a need to be clear with what we are calling something. I think we have some definitional issues. I think we heard that even listening to people in the second panel.

It reminds me of some 25 years ago when I first started in the area of mental retardation and all of what we called that; and now, when we talk about child abuse and neglect and the many things that are falling under that larger umbrella phrase, and to be very clear about what we are wanting to keep records on, how we can standardize this, not to be intrusive, to get the kind of information, because what we are really trying to then do is resolve the issue and not lay blame. I certainly hear what you are saying, and I would be very interested in working with the Committee to see how we best can get that done.

Senator **Dodd**. Well, I appreciate your saying that. And as I said, I would ask you to maybe look at the Presidential commission bill again.

Dr. **Elder**. All right, I will.

Senator **Dodd**. Again, I am not asking you to take a position on it today; that would be ludicrous of me to ask that. But if you would, take a look at it. It might be something that we could incorporate in the reauthorization act as a way of trying to get that data. You are absolutely correct; it really does present tremendous problems when you cannot rely on statistics, and you get all sorts of numbers thrown at you. It really is very difficult to legislate on that basis.

Dr. **Elder**. And as you and I both know, the one difficulty we have on this is that we have to be very clear about what we are calling something how we are defining it and what those parameters are.

Senator **Dodd**. Right. On a related issue, we had an ad hoc caucus on children's issues, which Arlen Specter and I chaired for about four or five years here, and we did hearings on data collection. In fact, we held a hearing at Children's Hospital here in Washington, which went rather well.

Out of that, though, came our concern about avoidable injuries being the number one killer of kids. And at that time, we, in a bipartisan way, asked the Administration to give us some help in developing a database on that particular question. There were a number of people including Arlen and I who initiated the letter. Frankly, the administration never answered. And it was not a question of saying we cannot do it or we do not have the personnel. We did not even get an answer.

Dr. **Elder**. On the second theme, on the accidental and suicidal death?

Senator **Dodd**. No, it was just accidental death at the time. And it was not a question of the Administration saying we are sorry, we do not have the personnel, or whatever; it was just no answer at all on it. And as I say, it was not a letter from me; we had 24 or 25 Senators were on those letters, going back and forth. And as I say, this is a new watch for me——

Dr. **Elder**. As it is with me, sir.

Senator **Dodd** [continuing]. So there may have been reasons why that happened. But it was always frustrating. We did not even get an answer or even an acknowledgment of a letter from 24 Members of the United States Senate with a request to build a data base on what is killing kids. This is not a question that ought to divide people along political lines.

So with that as background, I would urge you to do whatever you can to build up some support for your own idea, which I support.

Dr. **Elder**. Senator, I promise you that tomorrow morning, I will bundle up everything we have on Youth 2000 and send it up so you have some sense of where Dr. Bowen is on this issue and where Secretary Brock is. Perhaps in looking at that information, you could give us some good suggestions about things that we may have left out that you would like to see us include in that initiative, because I think it is really wonderful.

What I hear, as I go around the United States is that finally many of these issues are becoming public issues. And with public issues, there is the right kind of attention, there is the right kind of concern, and different and multiple solutions are presented. And that is what is so terrific about this Nation—once people know, they want to help.

Senator **Dodd**. I agree with you. I will tell you something about the place that I work in, though. There are two gears up there. There is no action and overreaction. That is about it, unfortunately. And what happens on these things is you get an issue that will come along, or a case, that will all of a sudden become the subject of terrific media attention. And then you get this explosion of people trying to outdo each other as to how big the problem is or how serious it is or how much money they are going to put into it. And you might as well just hang it up for a while until that thing slows down to the realm of reality again.

And what I hope we can start to do on this issue is to really get it into a proper framework. Obviously, it is going to be very difficult in many areas. In fact, one of the questions I have for Dr. Whitworth when he comes back up here is why the lowest numbers we get on the incidence of child abuse are from pediatricians. Of all things, doctors ought to be coming forth with data. There are some real problems in that area. So it is not easy to get the data in the first place. But it seems to me there has got to be a national commitment to try.

And in that regard, I have got to ask you why we are going to decrease the funding of $200,000, that traditionally pays for the national incidence study done by the American Humane Association. I gather what you are going to do is to survey a handful of States rather than try to get a national perspective.

Dr. **Elder**. I will let Dr. Burnley comment.

Senator **Dodd**. I will. And again, you can anticipate my questions. You have heard others, who are the professionals in this area, say that there is a danger involved in trying to pick out just a handful of States. It is not a question of getting huge bulks of numbers, but making sure you have a good cross-section, from the country. To rely on four or five or six States, I think, is risky.

Dr. **Burnley**. What you are talking about is the national study of reports of child abuse and neglect. We have provided support for some years to the American Humane Association.

Senator **Dodd**. Right.

Dr. **Burnley**. We took a short-term/long-term approach this last year. We asked them to decrease the investment and the effort with regard to reporting data this year while at the same time we have been analyzing what kind of reporting data in fact would better serve us and would be more effective. We have been evaluating that effort and we anticipate an effort that would be refocused and not represent an ongoing funding of the same thing year after year.

There are a lot of problems with the data that are available to the American Humane Association which is voluntarily provided by States to them for analysis. As you know, there are problems due to the lack of common definitions, the data is reported differently. It simply does not serve us as well as we would like. So what we have been concentrating on is an effort to evaluate what we would prefer to see and the reduction in our support for that particular reporting analysis was short term as we redesigned for the longer term.

I cannot tell you exactly how it is going to be changed because we are still studying it.

Senator **Dodd**. Well, we are not going to resolve it here this afternoon, but that is an issue that I would like us to work together on.

Dr. **Burnley**. Absolutely.

Senator **Dodd**. I still need to be convinced that we do not have the resource potential out there to do the kind of thing you are envisioning in the longer term approach, in a more prompt fashion. And again, I sit on the Budget Committee as well, and so I am painfully aware of the problems we have fiscally. I understand that there are a lot of priorities and a lot of people calling for various things out of the HHS budget. But this is one where I would like to at least see us, maybe, do a bit more than that, so I hope we can.

Dr. **Burnley**. In the area of data, I am sure you are aware we are also in the concluding stages of a national incidence study, which is different from the study of analysis of reports.

Senator **Dodd**. I understand that, yes.

Dr. **Burnley**. We expect to have the data available to us in the second incidence study in the month of June. So they will be available sometime in the very near future.

Senator **Dodd**. Again, Dr. Elder, I suppose the problem is I am asking questions about actions, many of which did not occur on your watch, but I must raise them anyway. Perhaps your two assistants can help you.

Your staff will recall that we had a real problem a few years ago in 1981, when the funding for sexual abuse under the National Center for Child Neglect and Abuse was dropped. I restored the funds in 1984. Early on in this decade, Kee McFarlane, who is well-known in this whole area, had her job eliminated as a result of these budget cuts.

I am told that after 1981, all the issues that came up with regard to sexual abuse were referred to Kee, who is now working in a private capacity out on the West Coast, and that continues. In 1984, as I said, we got the sexual abuse funds restored. Yet I do not know whether we have any experts in the National Center that are focused on sexual abuse. That was question number one. Now for question number two. I am told that the changes made in the definition of sexual abuse in 1984 have only just gone out to the States as of March 9th, about two weeks ago. That is almost three years later. I think an explanation is due.

Dr. **Burnley**. There are three questions that I would like to respond to. First of all, with regard to the earmarking of funds for sexual abuse related activities—prevention, research, intervention, et cetera—over the last several years, we have exceeded greatly, the level of earmark which at current appropriations has been at $3 million.

I cannot give you a specific figure; I would be glad to provide it for you. We have spent in excess of $3 million on various efforts related to the development of prevention programs, training of schoolchildren, the development of curricula, training of clinical staff, et cetera. There are numerous areas that we have focused on through our discretionary grant activities and, as I said, we have exceeded the earmarked level.

It is very true that Kee McFarlane represented a great source of expertise in the National Center prior to her departure, and she has continued her work, as you well know. We have undertaken an effort to develop that expertise within the National Center. We have designated a person in whom we have invested some opportunities for training.

Senator **Dodd**. Who is that person?

Dr. **Burnley**. Cynthia Darling. She has a master's degree in social work, and she joined the National Center sometime in the last two years. She manages a number of research projects related to child sexual abuse, and I think her concentrated attention to that area, has gradually increased her expertise.

We opened up the position as an opportunity and selected what we thought was a very talented professional who had skills to build on to develop that kind of expertise. I feel very pleased that we have found such a good person.

I have forgotten what your third question was—oh, the publication of regulations.

Senator DODD. Yes, three years later, we are just getting out the regulations.

Dr. BURNLEY. It is true, just this past spring we did publish the final regulations.

Senator DODD. "This past spring"—that is about two weeks ago.

Dr. BURNLEY. Yes. Well, we worked on them for a couple of years. The regulatory process does take a long time within our agency. There were three or four areas which we were concentrating on in those regulations to implement. These were the non-Baby Doe areas of the 1984 Amendments. I think that what we have published in fact is a good resolution of the issues, and they were fairly complex in sorting out. We got a number of comments, and all I can tell you is that at this point we have got the regulations published, and we are implementing them.

Senator DODD. Well, let me ask you this. You have a very slow process by which you get out regulations and definitions and so forth, and have taking three years on this one issue—which is not a minor one, by the way, and has been the subject of considerable discussion. But given that, has it been part of the practice of the Center to make studies that are being done by some States in this area available to other States and jurisdictions? I presume that is what you do, is that not true?

Dr. BURNLEY. Yes. Dissemination is done in a variety of ways. We fund a number of discretionary grants. Each grantee that has a product worthy of dissemination when it is finished is expected to develop a dissemination plan as part of its grant.

Senator DODD. They are?

Dr. BURNLEY. Yes.

Senator DODD. Not the Center?

Dr. BURNLEY. Every grantee is expected to develop a dissemination plan for products which they will be developing. The Center does assist grantees in doing that. Sometimes upon review of the products, we provide additional assistance for reproduction of products and dissemination of them.

Senator DODD. Well, without getting into the bureaucracy of it, let me just mention to you a couple of cases specifically. It is acknowledged by professionals in the field that the study on sexual abuse done by the State of Louisiana was one of the best that has been done. Now, I know for a fact, and I am sure or presume you are aware that the Commissioner in Louisiana wrote to the Center, asking that his study be distributed. By the way, I have read that study because the Louisiana Commissioner was one of my witnesses at a Children's Caucus hearing I chaired in New Orleans a year ago. Representatives from the Federal Government were also at that hearing. The experts that I listened to described the Louisiana study as one of the best and yet the National Center refused to disseminate that study nationwide.

Dr. BURNLEY. I cannot comment. I would be glad to get back you on that particular situation.

Senator DODD. Well, not so much me, but get back to the Commissioner, because that is how I know about it. He was highly upset over that, and others were as well—it is a very good study. Now, I am saying "a very good study." I am not a professional in the area, but I am relying upon the advice of people whose judgment I think we would all agree is pretty good. They claim that Louisiana study is excellent.

South Carolina has just done a study. Now, I am not competent to decide whether that particular study is worthy or unworthy. But it seems to me there again, if it is worthy, I would hope that one of the functions of the National Center is to get that study out to people.

It is not a question of bureaucracy at this point. This ought to be made available to the other States. This kind of a study is a real assistance.

Dr. BURNLEY. We are trying to do that.

Senator DODD. Try harder. It is frustrating to a lot of people.

Well, I have taken up a lot of your time already today on these things. I have made some recommendations to you on a couple of things, and I think they are important, Dr. Elder. I presume—do you have any idea what the process is for your confirmation—you are the "designee", aren't you, at this point?

Dr. ELDER. Yes, sir, that is correct.

Senator DODD. I do not understand these things. How long do we have to wait before you are onboard permanently? Are we slowing you down up here?

Do you require confirmation?

Dr. ELDER. Yes. Rumor has it that I will be "marked up" tomorrow morning.

Senator DODD. Well, why don't you attack me, and then I can guarantee you will go through like a hot knife through butter. That may be the quickest way.

Dr. ELDER. Well, that is just not my personality, sir.

Senator DODD. I know. I am not suggesting that.

Dr. ELDER. I am supposed to be "marked up" by the Finance Committee tomorrow morning at ten, and then I am hopeful that from there it will go to the Senate Floor. I have already been up for a confirmation hearing before the subcommittee which Senator Moynihan chairs.

Senator DODD. Well, you are new, and I am new. Let us pretend this is the first day of the rest of our lives on this issue, and——

Dr. ELDER. Well, I wish you well, and I have a feeling that you wish me well.

Senator DODD. I wish you well. But let us see if we cannot—I do not like to dwell on things that did not happen a year or two or three ago——

Dr. ELDER. Nor do I.

Senator DODD [continuing]. But if we can both agree that this is going to be a new start, then let us see if we cannot resolve some of the differences we have and really move forward on this. I think an awful lot of people, some of whom will never be witnesses or professionals, are really depending upon you and I. Now, we do the best we can, obviously. We are not going to solve the problem by a regulation or a law.

Dr. **Elder**. Well, I have a sense that both of us are very committed to stewardship, or we would not be where we are.

Senator **Dodd**. I thank you for that.

Dr. **Elder**. Thank you.

Senator **Dodd**. Thank you very, very much.

Dr. **Elder**. You are very welcome, Senator.

Senator **Dodd**. And since we still seem to have life here, I will ask the previous witnesses who were on the second panel to come back to the table.

I appreciate your staff Dr. Elder, by the way. They were very patient, were here all day, and listened very intently and took wonderful notes—I would like to read them all. So I thank them for being patient as well.

So if we could bring back the witnesses from the second panel. We lost one of the witnesses, I gather. Shirley Fitz-Ritson had to catch a 5:30 flight. Apparently there has been a death in her family.

Well, you all had the benefit of hearing the Administration. This is a unique way to conduct hearings: to have you testify, then have the Administration testify, so they hear you, and you have heard them. I would like to ask you to come back now and see if you have any codicils you would like to offer to your testimony.

I would like to begin with you, Anne, if we could, and get your quick comments. I think you all mentioned it in your testimony, but if I missed it—maybe there is a better idea than the Presidential commission on the data issue. But there seems to be some consensus, even with the Administration witnesses. Dr. Elder seems to be committed to it.

Is there maybe a better way we could do this, other than getting involved in the establishment of a Presidential commission, which may take on politically a larger problem than we need to? If the point is just getting the data, maybe there is a better way of doing that. I wonder if you have any comments on that to begin with—any one of you.

And Dr. Whitworth, you may want to comment, since I used your name in vain in your absence, about the problems with pediatricians.

Dr. **Cohn**. I certainly think the value of a commission can go beyond just data gathering, and I think there is a value in bringing together people from different Federal agencies and different agencies outside the Government to look at the range of child death issues and look at the commonality.

There is a lot of research that is segmented, and it would be valuable to bring it together.

It may well be that the implementation of standardized data gathering is something that could be done perhaps by the Communicable Disease Center or some other existing Federal agency. But I think a commission carries weight that will allow that to happen and carries enough clout to allow that agency then to work with the States to gather it. So I think it is a good idea; I do.

Dr. **Whitworth**. I do not think a commission is absolutely necessary, but a commitment that is reflected in the reauthorization bill or in the reauthorization proposal to that end, I think, would have the same effect. So whether it requires a commission or whether it requires specific language in the reauthorization bill, the effect I think would be the same.

Senator **Dodd**. Okay.

Mr. **Hollihan**. I think from our position, too, we are really concerned not only with the data but the public education that goes on, and I will support the other remarks that we can really bring some attention to it.

I have a specific concern around primary prevention. A lot of what has happened, when we talk about gathering data, is really at the position of waiting for the abuse to occur before we begin to tally it and we begin to intervene.

What I was referring to in my testimony related to early intervention services is critical when you are working with a high-risk population to try and prevent the whole incident from occurring. And a commission might be able to help focus on some of the community resources, the family support, the respite care and the sorts of things that are needed. So we are going well beyond the point of just collecting data.

Senator **Dodd**. Dr. Aber?

Dr. **Aber**. Two other brief issues about the commission. As I had a chance to speak with your staff, I come to view the child death issue as an opportunity for people on a new watch to refocus efforts on a broader issue. I think that the commission has a better chance to make a positive impact if it is focused on broader issues of child protection than if it is focused exclusively on the child death issue for political and other technical reasons. So that is one issue. I would like to see a slightly broader focus, although your proposed commission certainly provides impetus and energy.

The second issue: I would hate to see the attention devoted to a commission to distract us from some of the structural problems on which you were quizzing the Administration. The Center for Disease Control, the Census Bureau, a number of very competent research agencies within the Federal Government, have the ability to help us in this, and NCCAN is isolated from them.

That is not different from NCCAN's isolation from the basic research community and universities and research centers, and it goes to the issue you described of the nature of NCCAN—we have devoted public servants, but not enough of them, and without all the skills necessary to fulfill the mandate under the NCCAN legislation.

So that I think your focus on the structural issues should not be eclipsed by an exclusive focus on a commission.

Senator **Dodd**. Those are good suggestions.

Again, several of you have been very complimentary about the Challenge Grants, and you have heard the Administration. In fact, they can play games all they want, but the testimony we had today did not bring it up. The draft testimony we got last night specifically referred to their decision to repeal it. I am not going to hold them to last night's testimony. God knows, I change my speeches before I give them, and I would not want to have the draft I thought about giving become the text that everyone discusses. But Dr. Elder was honest enough to say they were going to oppose that.

I wonder if you might comment on that and comment on the question of the directorship issue. Again, I do not want to put too much attention on personalities, but it seems to bespeak of a larger problem.

Dr. Whitworth, I want to ask you about the pediatricians as well. And I can start with you on this one, too, Doctor. Is there a gap between the National Center on Child Abuse and Neglect and basic researchers? Are there potential areas of basic research that the National Center is not funding, but ought to be? Maybe you would like to comment specifically—you did in some of your testimony, but you could reiterate those.

Dr. **Aber**. There is a tremendous gap between NCCAN and basic researchers, and in discussions with individuals, I think that gap is recognized. And perhaps your Subcommittee under the new watch could quiz the Administration more closely on how they plan to close that gap. My sense is there is a little bit more receptivity to thinking this issue through and getting other areas of the Federal Government and the research community involved. But it needs a concrete plan. That goes to your issue of a full-time, on-the-job director who has the ability and time to do this. I think it is critical.

In terms of Challenge Grants, it seems to me that this Administration might respond to groups like the National Governors' Association who certainly would like to continue to see that program continue. Presently, Federal policy, if Dr. Elder's testimony represents the Federal policy accurately in its final form, flies in the face of what State governments want at the present time. So I would encourage getting the State governments involved in protecting the Challenge Grant Program for a little longer.

Senator **Dodd**. Let me ask you one other question. Then I will have completed the questions and I will not have to ask any more.

I raised the Louisiana study and the South Carolina study. And I talked about my general perception which was that people responded pretty favorably to that Louisiana study; I do not know as much about the South Carolina study. But if you would, please comment on them and the role of the National Center in dissemination of those kinds of things.

Dr. **Aber**. I think the National Center is candid in its recognition that it does not have in-house research expertise that it would take to evaluate such studies. I think until either such in-house expertise were available, or they were better able to use advisory councils in the way Anne Cohn has described to be able to evaluate this information, we are not going to get the kind of action on research studies that we need out of NCCAN. And I see it as a profound problem, one that goes to the heart of NCCAN's mandate from Congress. It is inconceivable that we would allow this kind of information to gap in several other areas. I think of AIDS, I think of SDI, where the Government is actively courting the research community. To do anything less here seems foolish at best, and it is not going to go away.

Senator **Dodd**. They are actively supporting the research community to support the programs. God help the research program that does not support them.

Dr. **Aber**. That is exactly right.

Dr. Cohn. I certainly can reiterate those comments. The gap between the research community and NCCAN is large, and it has been there for at least a decade. And I think in order to patch it up, it is going to take tremendous change—not a change in the number of dollars, but a change in the process that NCCAN would go through in funding research proposals.

If you look at the procedures used by the National Institute of Mental Health or any of the other health-related agencies in terms of judging the scientific merit of a proposed piece of research before they fund it, and then look at the process that NCCAN goes through and the people they use to review their research proposals, there is a dramatic difference. Researchers who have a lot of pride in their research capabilities do not really feel good getting grants from NCCAN. So the gap is large, and it has been there a long time, and it is going to be hard to shore it up. It can be shored up, and not even with more money just a change of procedure.

I think there is a tremendous amount that goes on in this field that NCCAN can and should be making the rest of the field aware of. That is the importance of a National Conference. That is the importance of advertising that there is a Clearinghouse. There are many things that go on like that Louisiana study that are tremendously beneficial to other States. When NCCAN finishes certain demonstration programs, NCCAN should not leave it up to that demonstration program, which no longer has money to disseminate information, but take on that responsibility themselves.

That probably does require a little more staff and some ingenuity. We advertise a lot that's going on in the field, on two sides of one piece of paper that we xerox and send out to 4,000 people every month. It does not take a tremendous amount of money, but it does take some staff to do that.

Senator Dodd. Well, that is the only place it is going to happen. I mean, enough of you know about State legislatures. You, Doctor, worked in the State government. And you go before the State legislature, and it is hard enough to get grant money or assistance to do something like this, but to ask for additional money so that you can then do the study and make it available to 40 other States, you have got a real political problem on your hands, just trying to get the funding.

Dr. Cohn. Yes. And I think this all ties into the issue of the directorship. I think NCCAN has got to have a highly-qualified, highly-motivated leader. To delegate the responsibility to somebody who is not a professional in the field or who is going to be detailed to another assignment, or to give it to an associate commissioner who is responsible for millions of dollars of other programs, does not make sense in my opinion. I think it is a more-than-full-time job, and we need a highly-qualified person there.

And then finally, the issue which I know is dear to your heart, the question of the Children's Trust Funds and the Challenge Grants. Certainly, you are to be commended for introducing that legislation, to work to get it enacted, and to get the appropriations for it. And I think the concept behind it was not simply to have trust funds set up in States, but to have trust funds set up in States that continue and that are stable over time. And that is why it was not a one-year piece of legislation; it was many years.

Interestingly enough, Arkansas and Georgia just passed trust funds this past week, we are now up to 40. Forty States have trust funds, but those funds are not well enough funded, and they are not stabilized. There is a tremendous need for incentives for them to grow and to continue. And I know personally, because we do have one small grant from NCCAN to work directly with the trust funds, that they look to the Federal Government for leadership and they enjoy, even though it is small, that small amount of Federal money they get as a match. It is a signal to the States that indeed prevention of child abuse is important.

So I think it is absolutely essential to continue that program.

Senator DODD. Dr. Whitworth?

Dr. WHITWORTH. Rather than reiterate, I simply will agree with what has been said.

I will comment on your question about reporting by pediatricians and physicians. If you look at the reporting rates and the reporting percentages, there is no question at all that physicians do not report child abuse. That has been true from the beginning of keeping statistics.

Pediatricians are about ten times more likely to report child abuse than other physicians who provide primary care to children. But still, it is not a phenomenal rate, and it is not a phenomenal percentage. And I think the reasons for it are basically twofold, historically.

One is lack of information. It has only been in recent years that physicians began to get good information about child abuse. And the second is fear—usually unfounded fear, but fear of possible retaliation by patients, fear of the court system, fear of the unknown social service system that they were reporting the child abuse to, and fear that they were reporting inappropriately.

What we found with the efforts that we have had in the State of Florida is that there has been a remarkable increase in reporting that is directly related to the number of hours of professional training that have been given in a given community. So we are continuing in that effort, and the Academy is continuing that effort on a national basis. And I believe the national statistics will show a change as well.

We are not wonderful, but we are getting better.

Mr. HOLLIHAN. I want to speak to a couple issues, because I feel that the issue around disabilities and abuse has been for so long ignored.

Senator DODD. And I apologize to you. I was going to get into that with Dr. Elder, because she has some expertise personally in that area. I do apologize. We will submit some written questions to her on that point. I felt like I had extended a little bit; she had been here for three hours or so, and that is not fair.

Mr. HOLLIHAN. Thank you. This is my third day on the job as a national program director, so I am learning a lot in the process. Some pieces fell into place today as I listened to Dr. Elder's testimony. Really, lack of leadership seems to be a real key and central issue. Prevention education—that information is not getting out, is of critical concern to the disability community, because I think it is only with the educational piece that we begin to figure out what to do.

I mentioned before, and I am going to stress again, the difference between primary prevention and really a response after an abusive incident has occurred. In my experience, I directed an infant program for seven years. All the kids in my program, and I worked with over 300 babies, who were in foster homes and placements—when you read the medical records, it was clear that abuse was there. Maybe there was not a criminal prosecution of the parent, but there was some real risk of abuse or in some cases, disabilities really being caused by abuse.

And it is real scary. Your first reaction is anger and rage inside of you at how could this happen to a kid. You need a lot of education to begin to understand that there are strategies, there are things you can do, how you can identify things, because you either respond with rage, or you want to walk away. And I think a lot of health care professionals really are afraid to look at the issue because they do not know what to do with it. And I think the Doctor's point was really good that as you begin to be educated, the real piece of the triangle that is missing is that there are some options we have. We can do some things. Some of them are legal, some of them are reporting. But what I would want a pediatrician to know is that, hey, there are some intervention strategies, there are some referrals, there is some support, there are some things that we can offer both kids and parents. I just would connect all of that with a drastic need to get that out around the country, and anything we can do in the reauthorization——

Senator DODD. Well, that is a very good point. I think as we push more for the National Center, in fact, to live up to its title, that should clearly be an essential piece of that effort.

And again, my apologies to you here about the disjointed fashion in which we have conducted this hearing today.

Mr. HOLLIHAN. One more quick comment. Maybe we just have to have them put one of those Federal disclaimers on everything that they send out, so they do not have to spend nine months on a policy analysis whether they support the position or not, but they can just send it out saying, "This is not Government-endorsed, but here is the information," and let people out there begin to make their own judgments.

Senator DODD. Not a bad idea.

Well, I thank all of you. It has been a long day for some of you—Anne, I know, who has been here from early this morning for our press conference—and I apologize. We started early this morning, ending up tonight on this issue, and we have a long month ahead of us where we can try and focus some attention.

In Dr. Elder's absence, I will say I was impressed with her statement. It was a good statement, I thought, and we will follow up on the recommendations made to her. I do not like to get into an acrimonious environment. It does not ever work. The people who suffer from that are the people you are trying to serve. Hopefully we can get the Administration to do some things without going through that process.

I have been asked to include statements by both Senator Adams and Senator Hatch in the record. I certainly ask unanimous consent that that be done and also to keep the record open for statements that other Senators may wish to make, either from the Subcommittee or the full Committee on this issue.

With all of that in mind, again, my apologies for the inconvenience today. But the bottom line is we got the job done.

This Subcommittee will stand adjourned until further call of the Chair.

[Whereupon, at 5:50 p.m., the Subcommittee was adjourned.]

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